STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555221	A. BUILDING _____ B. WING _____	R-C 11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURPRISE VALLEY COMMUNITY HOSPITAL D/P SNF	741 N. MAIN STREET CEDARVILLE, CA 96104

(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 California Department of Public Health during a recertification revisit survey conducted from 11/13/17 to 11/14/17. Representing the Department: 22705, Health Facilities Evaluator Nurse (HFEN); 38368, HFEN; 29582, Health Facilities Evaluator Supervisor (HFES), and 31709, HFES. Entity reported incidents (ERI) 553969, 555678, 557894, 557085, 559492, and complaint 559265 were investigated during the revisit survey. Deficiencies were written for ERI 553969 and 555678 at F 226. Deficiencies were written for ERI 559492 at F 226 and F 431. Deficiencies were written for ERI 557085 and complaint 559265 at F 334 and F 441. There were no deficiencies written for ERI 557894. Census: 17 Sample: 6	{F 000}		
{F 157} SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	{F 157}		

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

Jennifer Mayor | CEO | 11-22-17

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.

11/29/17 change made per facility administrator

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{F 157}	Continued From page 1 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:	{F 157}		

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{F 157}	Continued From page 2 Based on observation, interview, and record review, the facility failed to inform the physician of the need for a podiatry (foot doctor) referral for one of six sampled residents (Resident 1) when her toenails were thick, long, and ragged. This failure had the potential to cause Resident 1 discomfort during ambulation. Findings: A review of Resident 1's record indicated that she was admitted to the facility on 11/2/15 with diagnoses that included dementia with behaviors and chronic hip pain. A review of the Minimum Data Set (MDS, a standardized resident assessment), dated 8/11/17, indicated that Resident 1 was cognitively impaired and required supervision with her Activities of Daily Living (daily self-care activities). During an observation on 11/14/17 at 4 pm, Resident 1 wore open-toed shoes and the resident's toenails were thick, long, and ragged. On 11/14/17 at 4 pm, during a concurrent interview and record review, Licensed Nurse (LN) F acknowledged Resident 1's toenails had not been trimmed and that several of her toenails were thick and long. LN F stated Resident 1's toenails required trimming by a podiatrist due to possible fungus. After review of the record, LN F stated Resident 1 had not been seen by a podiatrist in the past two months and acknowledged that there were no referrals or recent orders for her to be seen.	{F 157}		
{F 226} SS=E	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	{F 226}		

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{F 226}	Continued From page 3 CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement its abuse policy when: 1. Two resident to resident altercations were not	{F 226}		

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{F 226}	Continued From page 4 thoroughly investigated for four of six sampled residents (Residents 2 and 4, and Residents 5 and 7). 2. An injury of unknown origin was not thoroughly investigated for one resident outside the sample (Resident 9) when Resident 12 sustained skin tears and bruises to her right arm. 3. Prior employment was not verified for two of five newly hired staff, and licenses were not verified for two of five newly hired staff. 4. An unusual occurrence involving an employee's job performance was not thoroughly investigated. These failures had the potential to result in recurring injuries and to expose the residents to abuse. Findings: The facility's "Elder Abuse" policy and procedure, dated 6/4/14, was reviewed. The policy read, "Investigation: Initiate steps to protect the resident, ensuring safety and comfort, document time this was implemented on the Investigation Statement form. 1. When abuse, mistreatment, neglect, or injuries of unknown origin of a resident is observed by, reported to, or suspected of any employee at this facility, staff immediately notifies their supervisor on duty. The supervisor assumes responsibility for taking the following steps during the investigation .... A. Immediately notify the Director of Nurses and/or Administration/HR in person or by telephone. B. Immediately investigate alleged incident during the shift on which the alleged abuse occurred.	{F 226}		

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{F 226}	Continued From page 5 Obtain written statements from all employees present, any parties involved and have them sign and date. Written statements should include facts, conversations and observations... 2. Interview the resident or other witnesses. This interview is to be dated, documented and signed by the witness and/or victim if able and the supervisor. 3. Give all completed forms to the Director of Nursing who then reports to the administrator ...." 1a. On 9/20/17, the facility reported to the California Department of Public Health (CDPH) that a resident to resident altercation had taken place on 9/20/17. The report indicated Resident 4 had wandered into Resident 2's room and that Resident 2 threw a glass of water on Resident 4. Resident 4's record was reviewed and indicated she was admitted to the facility on 8/21/15 with diagnoses that included Alzheimer's disease (memory loss). A review of a nurse's note, dated 9/20/17 at 10 am, indicated Resident 2 threw a glass of water on Resident 4 when she wandered, in her merry walker (ambulation device), into his room. A review of a nurse's note, dated 9/26/17, indicated that on 9/25/17 at 11 am, Resident 4 was cornered by Residents 2 and 7 and that kept Resident 4 from moving her merry walker. The note indicated Resident 7 kicked Resident 4's merry walker while Resident 2 blocked her. A review of the record revealed no further documentation regarding the incidents or that a thorough investigation had taken place in order to prevent recurrence and ensure Resident 4's	{F 226}		

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{F 226}	Continued From page 6	{F 226}		

safety when she wandered into other residents' rooms, placing her at risk for harm.

1b. On 10/4/17, the facility reported to the CDPH that a resident to resident altercation had taken place on 10/3/17. The report indicated Resident 7 would not let Resident 5 get by in the hallway.

A review of a nurse's note, dated 10/4/17 (no time), indicated Resident 5 was being physically harassed by Resident 7.

A review of the record revealed no further documentation regarding the incident or that a thorough investigation had taken place in order to prevent recurrence and protect Resident 5 from abuse.

During an interview on 11/13/17 at 2 pm, the Nurse Manager (NM) was asked about the resident to resident altercations that had taken place on 9/20/17 and 10/3/17, and for documentation related to the facility's investigations of the incidents. The NM was unable to provide the requested documentation and stated there was none. The NM confirmed no investigations had been conducted.

2. Resident 12's record was reviewed and indicated she was admitted to the facility on 1/17/08 with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life), osteoarthritis (joint pain and stiffness), chronic pain, and depression.

A review of a nurse's note, dated 9/26/17 at 7:15 am, indicated Resident 12 sustained a skin tear to her right upper arm.

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{F 226}	Continued From page 7 A review of a nurse's note, dated 9/30/17 at 10:30 pm, indicated Resident 12 sustained a skin tear to her right forearm. A review of a Skin Problem Assessment Form (Skin Tear), dated 9/30/17, indicated Resident 12 had a 24 millimeter skin tear and three bruises on her right forearm. Further review of the record revealed no documented evidence that an investigation into the cause of Resident 12's skin tears had taken place to ensure abuse was not occurring. During an interview on 11/14/17 at 12:45 pm, the Director of Nursing (DON) acknowledged there was a lack of documentation related to the investigations of injuries. During an interview on 11/14/17 at approximately 3 pm, the Nurse Manager (NM) stated there was no system in place to ensure follow up investigations had taken place and no Interdisciplinary Team meetings were being held. The NM acknowledged this had the potential to result in further injury and abuse. 3. The facility's "Elder Abuse" policy and procedure read, "Screening Procedures: [The facility] will follow the screening policy process for all potential hires to ensure the new employee is appropriate for employment. The Human Resources Manager will attempt to contact current employers and/or previous employers on all applications considered for hiring. Notations regarding information received will be made on the application next to the appropriate employer listing."	{F 226}		

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{F 226}	Continued From page 8 Additionally, the Elder Abuse policy read, "All applicants for positions requiring licensure will be subjected to clearance with the appropriate State Agency to ensure freedom from criminal conduct." On 11/13/17 at 4:30 pm, during a concurrent interview and review of employee files, the Human Resources Manager (HRM) stated criminal background checks included verification of prior employment and licensure. The HRM confirmed that prior employment was not verified for one of five employees who had been hired within the past four months, and that another employee's prior employment was not verified until nine days after her date of hire. The HRM stated that the license for one of five newly hired employees was verified but not documented, and that another employee's license had not been verified since 10/14/15, when she was previously employed. The HRM stated the facility had 30 days from the date of hire to obtain the verifications and acknowledged that this could result in a new employee working with residents prior to having a completed criminal background check. 4. On 11/2/2017 at 1:30 pm, the facility reported to CDPH (California Department of Public Health) that Licensed Vocational Nurse (LVN) O had been terminated due to two incidents of coming to work under the influence/altered and they suspected that she may have taken some narcotics. The facility's "Employee Handbook," revised 10/25/17, Section 701 titled "Employee Conduct and Work Rules," The following are examples of infractions of rules of conduct which violates our	{F 226}		

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{F 226}	Continued From page 9	{F 226}		

policy and will not be tolerated: Working under the influence of alcohol or illegal drugs, unsatisfactory performance or conduct.

LVN O's employee file was reviewed, it contained a note dated 11/3/17, referencing an incident that occurred on 9/14/17 written by another LVN. The note described that LVN O came into work an hour late, had her scrub top on inside out which she took off and put on correctly in a public room. The note described that LVN O had a blank look on her face and took a long time to respond when spoken too. LVN O was sent home by the Director of Nurses.

There was no other documentation in the employee file about the 9/14/17 incident.

LVN O's employee file contained a typed note dated 10/30/17 that referenced an incident that occurred on 10/26/17. The note documented that various members of the staff had thought that LVN O was impaired physically and mentally, when asked questions her answers did not logically correspond with the question, that her balance was contorted, and that she had severely slow movements when attempting to completing task.

LVN O's file contained one "Written Counseling Memo," dated 10/30/17. The Memo described an incident that had occurred on 10/26/17. The Memo stated that the LVN O had appeared incoherent, possibly under the influence, which impaired your ability to perform your duties. The memo noted "This kind of behavior jeopardizes the health and safety of our residents." The Memo was completed by the Nurse Manager (NM).

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{F 226}	Continued From page 10 On 11/13/17 at 1:45pm, during an interview the Administrative Assistant (AA) confirmed that she had sent the report to CDPH office. AA stated that she had reported both incidents. The AA confirmed that LVN O had been sent home after the 9/14/17 incident. The AA confirmed that the facility suspected that LVN O may have taken resident narcotic medication that was discovered missing on 10/5/17. The AA confirmed that there was no other investigation, counseling notes or interventions put into place after the 9/14/17 incident. The AA confirmed that the investigation for the missing narcotic was incomplete and stated that they do not drug test staff. The AA confirmed that LVN O was terminated after the 10/26/17 incident. On 11/14/17 at 10:10 am, during an interview the Nurse Manager (NM) confirmed that LVN O worked seven days in 9/17 and 11 days in 10/17. The NM confirmed that normally, that there is one registered nurse taking care of acute patients at one station and one nurse on the other station providing care for the skilled nursing residents. The NM confirmed that LVN O did not have direct oversite while providing care to the skilled nursing residents. The NM confirmed that LVN O was terminated on 10/31/17 because they were concerned about the health and safety of the resident.	{F 226}		
{F 281} SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	{F 281}		

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{F 281}	Continued From page 11 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services that meet professional standards for one of 8 sampled residents (Resident 3), when bowel care was not provided to the resident when clinically indicated. This had the potential to result in severe pain and medical complications. Findings: A review of Resident 3's record indicated that she was admitted to the facility on 4/21/14 with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life), diabetes, and high blood pressure. The most recent Minimum Data SET (MDS, a standardized comprehensive assessment of each resident's functional capabilities that helps nursing staff identify health problems) dated 11/3/17, was reviewed and indicated that Resident 3 was cognitively (the mental process of thinking, understanding, reasoning, and decision making) impaired and required maximum assistance with Activities of Daily Living (ADL's, self-care activities). A review of the facility documentation of Resident 3's bowel movements, on 11/14/17 at 9:30 am, indicated that Resident 3 had last had a bowel movement (BM) on 11/9/17. A review of the facility policy titled Bowel Care,	{F 281}		

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{F 281}	Continued From page 12 revised 7/26/17, indicated, "If no BM in 3 days give Milk of Magnesia [medication used to treat constipation] 30 cc at AM [morning]." Any bowel movement greater than 3 days shall be reported to the Director of Nursing (DON) and the bowel protocol shall be implemented." A review of Resident 3's Medication Administration Record (MAR) for 11/2017, indicated that Resident 3 had not received any bowel care medication, per the facility protocol and Physician order. During an interview, on 11/14/17 at 3:30 pm, the Director of Nursing (DON) confirmed that Resident 3 should have been given medication for bowel care per the facility protocol.	{F 281}		
{F 333} SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent a significant medication error for one of eight sampled residents (Resident 3). The physician ordered antibiotics to treat an infection and the medication was not given in a timely manner. This had the potential to lead to life threatening infection and a decline in health of Resident 3.	{F 333}		

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{F 333}	Continued From page 13 Findings: A review of Resident 3's record indicated she had been admitted to the facility on 4/21/14 with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life), diabetes and high blood pressure. A review of the Medication Administration Record (MAR) and physician's orders indicated a physician's order at 6:55 pm on 9/22/17 for Septra DS (an antibiotic typically used to treat urinary tract infection) one time a day for seven days. Resident 3 did not receive the first dose of medication until 9/23/17 at 8:00 am. A review of the facility's Policy and Procedure for Noting a Doctor's Order and Ordering of Medication, indicated, "whenever a medication has been ordered by a physician and it will not be available within 2 hours form the time of the order it is the nurse on duty responsibility to notify the ordering physician that the ordered medications are not available, obtain a new medication order that may be comparable and available or have the medication discontinued by the physician." During an interview on 11/14/17 at 3:30 pm, the Director of Nurses (DON) confirmed Resident 3's antibiotics were delayed because of pharmacy delivery issues. The DON implemented a new delivery system, but acknowledged that timely medication administration was a problem at the facility.	{F 333}		
{F 334} SS=D	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2)	{F 334}		

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{F 334}	Continued From page 14 (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	{F 334}		

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{F 334}	Continued From page 15 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that 4 of 4 residents (Resident 5 and out-of-sample Residents 9, 10, and 11) were given or offered influenza (flu) vaccines when the vaccines were readily available in the facility and the facility policy incorrectly identified the start of flu season as November 1 instead of October 1. This had the potential for the unvaccinated residents to develop influenza.	{F 334}		

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{F 334}	Continued From page 16 Findings: a. On 10/16/17, the California Department of Public Health (CDPH) received a letter, faxed from the facility, which indicated the facility had a respiratory outbreak, which started on 10/13 and 10/14/17, affecting five residents. On 10/17/17, CDPH received an updated list from the facility which indicated 12 residents were affected, three of which had tested positive for the flu. The facility policy titled "Immunizations", dated 5/31/17, was reviewed and indicated, "all residents (regardless of age) should receive influenza vaccine annually." This policy did not include a definition as to when flu season began or when vaccinations should occur. The facility policy titled "Immunization Policy for Employees", dated 8/4/17, was reviewed and indicated, "flu season shall mean the period of time from November 1 each year through March 31." During an interview on 11/13/17 at 2:15 pm, the Licensed Vocational Nurse Manager (NM) said they did not have the flu vaccines available for residents before the outbreak. NM said the prior DON had called the company that supplies the medications for the hospital and was told they were out of flu vaccines. NM confirmed none of the residents were vaccinated before the outbreak, except for one resident whose family took her to a flu vaccination clinic where she received the flu vaccine. This resident was not on the list of residents who became ill. NM stated it was sometime during the outbreak before they	{F 334}		

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{F 334}	Continued From page 17 got the flu vaccines from County Public Health. During interviews on 11/14/17 at 9:50 am and 10:20 am, the County Public Health Nurse (PHN) said they were notified by the facility of several residents who had become ill with flu like symptoms who had not received the flu vaccine. She stated flu vaccines were delivered by County Public Health to the hospital on 10/19/17. b. A list of resident names and the dates each received the flu vaccine was reviewed. There were four residents (Resident 5 and out-of-sample Residents 9, 10, and 11) who were unaffected by the flu (it is recommended to not get a flu shot while you are ill with a fever), but did not receive a flu vaccine until 11/1/17, even though the facility had received the vaccines by 10/19/17. During an interview on 11/14/17 at 11:10 am, NM was asked why there was a delay in giving the flu vaccine to the above referenced four residents. NM stated another nurse was supposed to give the vaccines, but vaccinated only two other residents on 10/20/17. The flu vaccines were then kept locked up by one of the night shift RN's in the pharmacy hospital medication room. Only RN's can enter that room and the night shift RN refused to give the vaccinations to the other residents and would not give the vaccines to other nurses so they could vaccinate the residents.	{F 334}		
{F 371} SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or	{F 371}		

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{F 371}	Continued From page 18 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow it's policy and procedures for food storage in the kitchen and in the resident nourishment refrigerator when numerous food items were found to be expired or unlabelled. This had the potential to negatively impact the health of the residents. Findings: 1. During a concurrent initial kitchen tour and interview with the Certified Dietary Manager (CDM), on 11/13/17 at 1:15 pm, a container of buttermilk with the expiration date 11/02/17, was	{F 371}		

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{F 371}	Continued From page 19 in the walk-in refrigerator. The CDM threw the buttermilk away, confirming that it was beyond it's expiration date. 2. During an observation of the kitchen freezer on 11/13/17 at 1:25 pm, a bag of cooked sausage had visible ice build up inside the bag and a use-by date of 7/14/17. A bag that contained cooked roast beef was dated 6/20/17 and had no use-by date. The CDM threw both items in the trash. The CDM supplied a document, Storage of Frozen Foods from a Serving Safe Food Certification Coursebook. The document lists 2-3 months as a maximum storage period for leftover cooked meats. The CDM stated that both meats were beyond their safe storage period and the roast beef should have had a use-by date written on the bag, per policy. 3. On 11/13/17 at 1:45 pm, during an observation of a kitchen refrigerator that contained poured juices, milk and other items for immediate service, a staff juice bottle and a container of yogurt with an expiration date of 11/2/2017 were noted. The CDM confirmed the yogurt had expired and that staff sometimes place their drinks in the resident food areas. 4. During a concurrent observation and interview on 11/13/17 at 2:10 pm, while examining the contents of the resident nourishment refrigerator at the south nurses' station, outdated items were noted. A yogurt with an expiration date of 10/31/17, and slices of cheese and bread with the expiration date of 11/08/17 were observed. An unlabelled bag of lettuce and a bag of lettuce with a resident's name, had no expiration date. All items were thrown away. The CDM stated that it is the responsibility of the evening cook to	{F 371}		

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{F 371}	Continued From page 20 examine the nourishment refrigerator and pull expired food items. She further reported that all staff knew to label all food before it went into the refrigerator and that it was to be thrown out after three days. A record review of the facility document, Policy and Procedure for Food for Residents from Outside of Facility, Board Approved 7/26/17, indicates " perishable food from family members...shall be labeled and dated when placed in the refrigerator. The item will be discarded after three days." A facility document, Policy and Procedure for Food Storage, Board Approved 2/1/17, indicated that all products shall be dated, labeled and rotated according to First In and First Out rule.	{F 371}		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		

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F 431	Continued From page 21 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure:	F 431		

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F 431	Continued From page 22 1. An accurate process for reconciliation of controlled medications (a medications that have the potential for abuse and/or addiction, which are held under close government oversight) when an undisclosed amount of the medication Norco (a narcotic, a combination of hydrocodone bitartrate and acetaminophen used to treat pain), was unaccounted for; 2. They had a procedure for pharmaceutical services, which assure the accurate acquiring, and receiving of medications to meet the needs of each resident when no delivery manifest was provided by the pharmacy. These failures had the potential for medications including controlled drugs to be diverted (transfer of a legally prescribed controlled medication from the individual for whom it was prescribed to another person) for potential misuse or abuse. Findings: 1. On 11/2/2017 at 1:30 pm, the facility reported to CDPH (California Department of Public Health) that an undisclosed amount of Norco was discovered missing from the medication cart on 10/5/17. On 11/13/17 at 2:10 pm, during an interview the Admin (Administrator) was asked for their report or investigation regarding the missing Norco. The Admin stated that there was no documented investigation. The CEO stated that the facility was planning to complete a root cause analysis on the missing Norco but had not started the process. On 11/13/17 at 2:45 pm, during an interview and review of the facilities theft and loss report, dated	F 431		

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F 431	Continued From page 23	F 431		

10/6/17, the AA (Administrative Assistant) confirmed that of the six nurses listed on the report four continue to work at the facility and have access to all the medications. The AA confirmed the report listed the missing item as "Medication card (a method of packing medications, where each dose of medication is sealed individually in a plastic bubble on a card), Norco 5/325 mg." The AA stated, the prior Director of Nurses (DON) indicated that he interviewed the nurses listed on the report. The AA stated she does not have documentation of the interviews or any investigative notes regarding the incident. The AA stated, it was reported to the police who had not yet completed their investigation.

On 11/14/17 at 10:35 am, during an interview and observation of the locked medication cart and the medication room Licensed Nurse (LN) F stated that there was one partial Norco card missing from the medication cart with the sign out sheet and one unused Norco card with the sign out sheet missing from the locked medication room. LN F showed that the Norco, which is a controlled medication, was double locked in the medication cart and in the medication room.

On 11/14/17 at 10:55 am, during an interview the current DON confirmed that there was one full card and one partial card of Norco missing. The DON stated she did not know the total number of Norco missing was unable to find any information regarding an investigation of the missing Norco.

On 11/15/17 at 1:15 pm, during a phone interview the facility's Consulting Pharmacist (RPh.) confirmed that he was notified about the missing Norco. The RPh. stated he provided the prior

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F 431	Continued From page 24 DON ideas on how to investigate the missing medications. The RPh. stated that he visited the facility on 10/26/17. The RPh. stated that the DON was no longer there. The RPh stated that there was no record of an investigation and no one in the facility had information on the investigation. The RPh stated that he has not initiate an investigation of the missing Norco. The facility's "Pharmacy Service Agreement" signed by the pharmacist on 9/25/15, indicated the Consultant Pharmacist responsibilities were a. Review and revise Medication Management Policies and Procedures...j. Review and approve audit plans for control of narcotics ...and identify corrective actions as needed. The facility's undated policy, titled, "Pharmacy Policy and Procedures," indicated all narcotics are accounted for ...if there is any discrepancy when reconciling narcotic the Director of Nursing Services must be notified before the second licensed personnel doing the count leaves their shift. If the DNS is not able to resolve discrepancy, the Consulting Pharmacist and the Administrator must be notified as an unusual occurrence. The facility's policy, titled, "Unusual Occurrence Reporting," revised 7/2016, indicated the goal was to review unusual occurrences for performance improvement opportunities by the Quality Assurance Performance Improvement Program. 2. On 11/14/17 at 10:35 am, during an interview and observation of the facility's medication room LN F described the medication ordering process. LN F stated that the nurses complete a	F 431		

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F 431	Continued From page 25 medication order sheet and fax it to the pharmacy. The pharmacy delivers twice a week. If medications are needed before the regular delivery one of the licensed nurse will pick up the medication from the pharmacy. LN F reviewed the order sheets and explained that the pharmacy at times will send more or different medications then what is on the order sheet. LN F stated that they add the new medications to the bottom of the order sheet. LN F stated that they do not receive a delivery list or manifest with the medications delivered. On 11/14/17 at 12:30 pm, during an interview the Nurse Manager (NM) confirmed the nurses add the extra medication delivered to the order sheet. The NM was asked about a delivery list or a manifest to reconcile medications ordered with the medications delivered and confirmed that it is not routinely provided. The NM stated that they had received them in the past but they have a tendency to fade and become unreadable. On 11/15/17 at 1:15 pm, during a phone interview the facility's Consulting Pharmacist (RPh.) stated that he was unaware that the pharmacy was not providing a medication delivery list.	F 431		
{F 441} SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	{F 441}		

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{F 441}	Continued From page 26 investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	{F 441}		

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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
{F 441}	Continued From page 27 contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement an infection control program that was designed to provide a safe and sanitary environment to prevent the transmission of infection and disease when: 1. The facility policy definition was inaccurate when it incorrectly identified the start of influenza (flu) season as November 1 instead of October 1 as stated in federal regulations under F 334 and the infection control and isolation practices during an influenza outbreak were inadequate when group activities were canceled for only 48 hours and there was insufficient Personal Protective Equipment (PPE - masks, gowns, and gloves). This resulted in the potential for resident not to have flu immunity during the flu season and the potential for flu or other communicable diseases to be spread to resident, staff, and visitors.	{F 441}		

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{F 441}	Continued From page 28 2a. After the facility had available flu vaccines, there was a delay of 13 days before the flu vaccinations were given to four of five residents (Resident 5 and out of sample Residents 9, 10, and 11) who were unaffected by the flu outbreak and 11 of 12 residents who were symptom free by 10/21. 2b. Several staff did not receive the flu vaccine and continued to care for or come into contact with residents, without wearing a mask, as required by facility policy and Department of Public Health mandates. This had the potential to result in additional or prolonged flu outbreaks for all residents who reside in the facility as well as staff. 3. The facility failed to provide annual PPD tests (skin tests to check for Tuberculosis, an infections respiratory illness) for two of six sampled residents (Resident 2 and 3). This had the potential to result in infections for all residents who resided in the facility as well as staff. Findings: 1. According to the Centers for Disease Control and Prevention (CDC), "the primary option for reducing the effect of influenza is immuno-prophylaxis with vaccine. Inactivated (i.e., killed virus) influenza vaccine and live, attenuated influenza vaccine are available for use in the United States ....Vaccinating persons at high risk for complications and their contacts each year before seasonal increases in influenza virus circulation is the most effective means of reducing the effect of influenza ...When vaccine	{F 441}		

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{F 441}	Continued From page 29	{F 441}		

and epidemic strains are well-matched, achieving increased vaccination rates among persons living in closed settings (e.g., nursing homes and other chronic care facilities) and among staff can reduce the risk for outbreaks by inducing herd immunity. Vaccination of health-care workers and other persons in close contact with persons at increased risk for severe influenza illness can also reduce transmission of influenza and subsequent influenza-related complications. Antiviral drugs used for chemoprophylaxis or treatment of influenza are a key adjunct to vaccine ...However, antiviral medications are not a substitute for vaccination."

During an interview on 11/13/17 at 1 pm, the Administrator stated she, the Director of Nurses (DON), who works night shift, and a Paramedic had all been working on infection control, but the facility had no designated Infection Control Nurse at this time.

On 10/16/17, the California Department of Public Health (CDPH) received a letter, faxed from the facility, which indicated the facility had a respiratory outbreak, which started on 10/13 and 10/14/17, affecting five residents. This letter also indicated the facility had instigated CDPH "Recommendations for the Prevention and Control of Influenza in California Long Term Care Facilities." These recommendations included: implement standard and droplet precautions (wearing a mask, gown, and gloves when caring for a resident, a mask when entering the room) for a resident with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer; confine first symptomatic resident and exposed roommate(s)

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{F 441}	Continued From page 30 to their room, restrict them from group activities, and serve meals in their room; if other residents become symptomatic, cancel group activities and serve all meals in resident rooms; wear gown and gloves when providing direct care to a symptomatic resident or in contact with contaminate surfaces; change gowns and gloves after each encounter with symptomatic resident and perform hand hygiene. On 10/17/17, CDPH received an updated list from the facility which indicated 12 residents were affected, three of which had tested positive for the flu. The facility policy titled Immunizations, dated 5/31/17, was reviewed and indicated, "all residents (regardless of age) should receive influenza vaccine annually." This policy did not include a definition as to when flu season is or when this should occur. The facility policy titled Immunization Policy for Employees, dated 8/4/17, was reviewed and indicated, "flu season shall mean the period of time from November 1 each year through March 31." During interview on 11/14/17 at 9:50 am and 10:20 am, the County Public Health Nurse (PHN) said they were notified by the facility of several residents and staff who had become ill with flu like symptoms who had not received the flu vaccine. She stated flu vaccines were delivered by County Public Health to the hospital on 10/19/17. PHN stated the facility initially said they had PPE, but she knew if the PPE was properly used, the facility would run out, so they also provided PPE to the facility on 10/19/17.	{F 441}		

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{F 441}	Continued From page 31 On 11/14/17 at 7:50 am, Environmental Services Staff (EVS) was asked where gowns and masks were kept. She entered Room 4 (no residents) and opened the bedside table where there were 11 isolation gowns. On 11/14/17 at 8 am, NM opened an isolation cart that was in the hallway close to Room 14. This cart had 29 isolation gowns. NM stated that was probably not enough if they had another outbreak so they would have to get more from County Public Health. On 11/14/17 at 11:40 am, the DON said they had PPE in the "warehouse". She went outside the hospital to a room connected to the back of the facility and unlocked the door. Inside was one unopened box that contained 50 isolation gowns. During an interview on 11/14/17 at 12:50 pm, NM was unaware of the "warehouse" having extra gowns and stated it's kept locked and she was unaware of who had the keys when the central supply staff were not working. During an interview on 11/14/17 at 2:15 pm, Central Supply and Purchasing staff (CS) stated when she was not working, the Registered Nurse (RN) on duty would have access to the key. She supplied a copy of the last time isolation gowns were ordered, which was on 7/25/17, at which time one box with 50 gowns was ordered. During an interview on 11/14/17 at 9 am, the Paramedic (PM) said he was the infection preventionist and had received some training from the prior DON. He stated he was aware of the first three residents	{F 441}		

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{F 441}	Continued From page 32 who became ill, as reported to CDPH. He stated the residents just kept getting sick. PM provided a list of actions taken for the flu outbreak starting 10/14/17, that included cancellation of all group activities for 48 hours. PM said he had been told to cancel group activities for 48 hours which would have been over the weekend of 10/14 and 10/15/17. PM said group activities were canceled for only 48 hours after which affected residents weren't supposed to go to activities. PM said he doesn't work on the floor so he doesn't know if staff wore masks and gowns when caring for ill residents. 2a. During an interview on 11/13/17 at 2:15 pm, the Licensed Vocational Nurse Manager (NM) said they did not have the flu vaccines available for residents before the outbreak. NM said the prior DON had called the company that supplies the medications for the hospital and was told they were out of flu vaccines. NM confirmed none of the residents were vaccinated before the outbreak, except for one resident whose family took her to a flu vaccination clinic where she received the flu vaccine. This resident was not on the list of residents who became ill. NM stated it was sometime during the outbreak before they got the flu vaccines from County Public Health, as well as PPE. She said, as far as she knew, they had run out of PPE during the outbreak. A review of the list of resident names and dates each received the flu vaccine was reviewed. There were four residents who were unaffected by the flu (it is recommended to not get a flu shot while you are ill with a fever), but did not receive a flu vaccine until 11/1/17, even though the facility had received the vaccines on 10/19/17. The symptoms of the 12 ill residents had subsided by	{F 441}		

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{F 441}	Continued From page 33 10/21/17, and 11 of them also were not vaccinated until 11/1/17. During an interview on 11/14/17 at 11:10 am, NM was asked why the above four referenced residents were not given the flu vaccine as soon as the facility received it on 10/19/17. NM stated another nurse was supposed to give the vaccines, but vaccinated only two residents on 10/20/17. The flu vaccines were then kept locked up by one of the night shift RN's in the pharmacy hospital medication room. Only RN's can enter that room and the night shift RN refused to give the vaccinations to the other residents and would not give the vaccines to other nurses so they could give vaccinate the residents. 2b. On 11/14/17 at 7:50 am, Environmental Services Staff (EVS) was observed not wearing a mask. On 11/14/17 at 10:45 am, the Activities Staff / Certified Nursing Assistant (AS/CNA) was observed not wearing a mask. She was asked if she had received a flu shot and said no. AS/CNA said she has not been wearing a mask because she didn't think she needed to do so unless she had symptoms. During numerous observations on 11/13/17, Medical Records Manager (MRM) and Medical Records Staff (MRS) were observed not wearing a mask while in resident hallways. On 11/14/17 at 11:30 am, they were observed wearing masks and MRM confirmed she had not received a flu shot. On 11/13/17, Certified Nursing Assistant (CNA) A was one of three CNAs who worked day shift.	{F 441}		

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{F 441}	Continued From page 34 During an observation, CNA A did not wear a mask on 11/13/17, but wore one on 11/14/17. On 11/14/17 at 3 pm, Activities Aid (ACTA) was sitting at a table with two residents in the activity room and was observed not wearing a mask. The Human Resources Director provided a list of employees who had not received the flu vaccine. This list was reviewed and included EVS, AS/CNA, MRM, MRS, CNA A, and ACTA. During an interview on 11/13/17 at 2:15 pm, NM said staff who did not receive the flu vaccine needed to wear a mask while at work. She said she did not have a list of which staff have not received the flu vaccine, so she did not know if this was being done. The facility policy titled Immunization Policy for Employees, dated 8/4/17, was reviewed and indicated, "a mask will be worn in direct patient care areas for those who refuse the vaccination." It also indicated the facility, "will provide influenza vaccinations free of charge to all employees, contract employees, and volunteers." A letter to all hospitals and skilled nursing facilities, dated 10/1/14, was reviewed and stated that County Public Health mandated all health care workers receive an annual flu vaccination, or if they decline, to wear a mask in patient care areas during the flu season. 3. Resident 2's record was reviewed and indicated he was admitted to the facility on 11/25/15 with diagnoses that included hemiparesis (paralysis of one side of the body), depression, Coumadin therapy (for prevention of	{F 441}		

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{F 441}	Continued From page 35 blood clots), and seizure disorder. A review of Resident 2's Immunization/Vaccination record indicated Resident 2 was last given a PPD on 6/30/16. During a concurrent interview and record review, on 11/14/17 at approximately 11 am, Licensed Nurse F reviewed the immunization record for Resident 2 and confirmed that the most recent PPD was completed 6/30/16, more than 16 months ago. During an interview on 11/14/17 at 11:15 am, the Nurse Manager (NM) stated all residents were to be screened for TB upon admission and annually. The NM stated all routine orders for TB screening had been discontinued by the former physician and that the facility was in the process of renewing those orders.	{F 441}		