POC Accepted
Tom Popkins
11/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054093	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 000	INITIAL COMMENTS	A 000		

The following reflects the findings of the Department of Public Health during a recertification survey.

Representing the Department of Public Health:

Surveyor 22458, HFE, Nursing
Surveyor 36329, HFE, Nrsing
Surveyor 16281, HFE 1, REHS
Surveyor 39840, Medical Consultant
Surveyor 28851, Pharmacy Consultant
Surveyor 10933, Dietary Consultant

Sample Size: 34

On 8/1/18 at 2:55 p.m., the team was informed by the Dietary Consultant of adverse conditions in the facility kitchen

On 8/2/18 at 2:20 p.m., the facility Director, Director of Quality Assurance, and Chief Nursing Officer (CNO) were informed of the presence of an Immediate Jeopardy (IJ) situation in Dietary services relating to infection control.

On 8/2/18 at 5:40 p.m., a Plan of Action was presented to the survey team by the Chief Nursing Officer (CNO).

On 8/3/18 at 3:05 p.m., the Director, CNO, and Director of QA were informed that the IJ was abated.

Five (5) Conditions of Participation were not met during the Recertification survey; 42 CFR 482.12 Governing Body, 42 CFR 482.21 QAPI, 42 CFR 482.28 Food and Dietetic Services, 42 CFR

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President & CEO	10-19-18

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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A 000	Continued From page 1 482.41 Physical Environment and 42 CFR 482.42 Infection Control.	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview and review of documents supplied by the hospital, the Governing Body failed to effectively carry out its responsibilities for the operations of the hospital. 1. The Governing Body failed to ensure the development, implementation, and maintenance of an effective, ongoing, hospital-wide, data-driven Quality Assessment and Performance Improvement (QAPI) program. (Refer to A-0263) 2. The Governing Body failed to ensure the development, implementation, and maintenance of an active hospital-wide program for the prevention, control, and investigation of infections and communicable diseases. (Refer to A-0747) 3. The Governing Body failed to ensure the hospital's food and dietetic services was directed and staffed by adequate qualified personnel to meet the nutritional needs of the patients in accordance with practitioners' orders and acceptable standards of practice. Failure to identify deficient food safety practices that	A 043	Plan of Correction for each specific deficiency cited: (A-043) The Governing Body failed to effectively carry out its responsibilities for the operations of the hospital. 1. Refer to A-0263 and the corrective actions stated therein. The Governing Board will ensure compliance evidenced by monthly reporting by the Director of Quality Management via QAPI Reports. 2. Refer to A-0747 and the corrective action stated therein. The Governing Board will ensure compliance evidenced by various reporting mechanisms such as bi-monthly IC meetings, MEC, QAPI, and Governing Board. 3. Refer to A-618, A-619, A-620, A-621, A-629, A-630, A-724, and A-749) and the corrective actions stated therein.	7/24/2018 9/3/2018

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A 043	Continued From page 2 resulted in an immediate jeopardy situation. (Cross refer A 618, A 619, A 620, A 621, A 629, A 630, A 724, A 749) 4. The Governing Body failed to ensure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. (Refer to A-093) The cumulative effect of these systemic problems resulted in the Governing Body's failure to ensure provision of quality health care to patients in a safe environment.	A 043	4. There is currently a policy reference #2033 - Emergencies - Medical which was redistributed to staff on October 15, 2018, along with the "Procedure for Medical Emergencies". (Attachment A)	10/17/2018
A 091	EMERGENCY SERVICES CFR(s): 482.12(f) Emergency Services This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure patient safety and well-being, by failing to: 1. Ensure staff on Adult Inpatient Unit (AIP) 1 and AIP 2 were aware of a change in the emergency equipment, which had the potential to result in delayed emergency response for patients. 2. Ensure the maintenance date had not expired for one of two oxygen (O2) tanks on AIP Unit 2, and that the tanks were easily accessible, in order to prevent delay in treatment in the event of an emergency, and ensure biomedical maintenance was conducted prior to the expiration dates for two out of two O2 tanks on the Children's Inpatient Unit (CIP). 3. Ensure staff on the CIP Unit were checking the	A 091	A091 PLAN OF CORRECTION: 1) In-service ER Kit location and contents and use of contents. 2) Contact oxygen and regulatory company to in-service on oxygen in Nursing Station for easy accessibility in case of ER. 3) In-services will be held on October 30, 2018 at change of shift. Staff will sign and keep log. 4) Nursing Managers will monitor ER kit review and oxygen monthly for Licensed Nurse signatures. 5) Nurse Manager will audit monthly and evaluate the process: (Attachment B) 3. The crash cart have been removed from the CIP Unit 10/17/2018	10/30/2018

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A 091	Continued From page 3 Emergency Cart on a regular basis, in order to prevent inadequate supply of supplies and equipment in the event of a medical emergency. Findings: 1. On 8/3/18 at 11 a.m. on Adult Inpatient Unit (AIP) 2, when RN7 was asked the location of the Emergency Cart, he pointed to an area behind the desk in the Nurses Station, and stated the cart was supposed to be there, then stated the pharmacy staff may have taken the cart in order to restock it. Several other staff members also stated the Emergency Cart was kept in the Nurses Station. RN 1 then obtained a plastic orange box from AIP Unit 1 that contained an Ambu Bag, stethoscope, and blood pressure cuff and stated the Emergency Cart had been replaced by the box several months ago because it was easier to take to an emergency. 2. On 8/3/18 at 11 a.m. on Adult Inpatient Unit (AIP) 2, two O2 tanks were observed in the Valuables Closet, which was kept locked. The Chief Nursing Officer (CNO) stated the tanks were supposed to be located against the wall of the Nurses Station and not locked up, in order to be accessible in the event of an emergency. 3. On 8/3/18 at 9:35 a.m., during an observation of the Treatment Room on Children's Inpatient Unit with RN 5, a review of the Signature Sheet on the Emergency Cart indicated the emergency medications were checked on a daily basis, however, there was no indication that the supplies in the cart were also being checked. RN 5 stated the cart should be checked every day. Two out of two O2 tanks in the Treatment Room	A 091	and emergency kits are now being utilized. Evidence of standard compliance is being monitored by weekly and monthly tracers conducted by the CQI team.	

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A 091	Continued From page 4 had expired maintenance dates. RN 5 acknowledged the dates had expired, and that he would inform the Maintenance Department.	A 091		
A 093	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Based on interview and review of documents supplied by the hospital, the hospital medical staff failed to adopt written policies and procedures for the management of medical emergencies, including appraisal, initial treatment, referral and transportation of individuals with emergencies. Findings: Interview conducted on 8/2/18 at 1400 hours with the Medical Director. When asked about the hospital's policy for handling persons with medical emergencies, the Medical Director stated that a physician is always on-call and all medical staff are certified in Basic Life Support (BLS). If medical staff are present on-site, they will directly participate in emergency care, whereas during after-hours when only on-call coverage is available, the nurses call the on-call physician for direction. He added that if the on-call physician cannot be reached immediately, he usually serves as backup and the nurses can call him. Interview conducted on 8/3/18 at 0955 hours with the Charge Nurse for Adult Inpatient Unit 1 (RN	A 093	Reference policy #2033 - Emergencies - Medical which 10/15/2018 was redistributed to staff on October 15, 2018, along with the "Procedure for Medical Emergencies". (Attachment A) A093 PLAN OF CORRECTION: 1) In-service policy 2) In-service staff at change of shift or policy, pre-test and post-test. 3) Monitor in the event of ER, all actions will be evaluated on a case by case basis. 4) DON will audit and evaluate each ER situation.	11/20/2018

Reference policy #2033 - Emergencies - Medical which 10/15/2018 was redistributed to staff on October 15, 2018, along with the "Procedure for Medical Emergencies".
(Attachment A)

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A 093	Continued From page 5 1), in presence of another registered nurse on duty (RN2). When questioned about how they address and care for persons in emergency conditions, RN1 stated she would first assess the individual, stabilize, notify the physician on duty or on-call, and if needed, call 911 and transfer the individual to an acute care hospital. She added all nursing staff are BLS-certified and trained to perform CPR. RN2 agreed with the stated protocol. The Medical Staff Bylaws Section 7.5 Emergency and/or Disaster Privileges, dated October 2014, reads: "(a) In the case of an emergency, any Physician, to the degree permitted by his or her license and regardless of department, staff status, or Clinical Privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The physician shall make every reasonable effort to communicate promptly with the Medical Director concerning the need for emergency care and assistance by Members of the Medical Staff with appropriate Clinical Privileges, and once the emergency has passed or assistance has been made available, shall defer to the Medical Director with respect to further care of the patient at the Hospital." "(b) In the event of an emergency, any non-Physician shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such non-Physicians shall promptly yield such care to qualified Members of the Medical Staff or other Physician when he or she becomes available. On 8/2/18 at 1530 hours [3:30 p.m.], when requested to provide a written policy and	A 093	Reference policy #2033 - Emergencies - Medical which 10/15/2018 was redistributed to staff on October 15, 2018, along with the "Procedure for Medical Emergencies". (Attachment A)	

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A 093	Continued From page 6 procedure on hospital's management of medical emergencies, the Director of Quality Management stated she was unsure whether a written policy was available but she would look for it. Subsequently, she indicated she did not identify any such document.	A 093	Reference policy #2033 - Emergencies - Medical which was redistributed to staff on October 16, 2018, along with the "Procedure for Medical Emergencies". (Attachment A)	10/16/2018
A 117	PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to display the correct phone number and address of the State agency responsible for receiving reports of complaints as per regulation. The facility also failed to ensure the legal guardian of an underage patient received and acknowledged the patient's rights and related documents. Findings: 1. Upon entering the facility on 7/31/2018 at 8:20 AM, it was noted that the information located on the wall in the reception area of the lobby for addressing complaints was only for the Department of Mental Health; no address was listed for the California Department of Public Health. At that time, the Director of Nursing Primary Care (DONPC) stated she did not know the correct address; she was given the correct address and	A 117	A117 PLAN OF CORRECTION: 1) Information signs are developed with correct agency telephone numbers and addresses to voice and receive written complaints. 2) Signs have been placed in visiting areas as well as each telephone on the unit. 3) Visual check will be made on 11PM/7AM shift daily to ensure signs are maintained on the unit. These will be signed by the Charge Nurse on duty. 4) Nurse Manager will monitor sign placement on Adult and Children's Units. *Parent's/legal guardian of minor patients shall sign that they received and acknowledged "Patient's Rights" and related documents. On October 15, 2018, additional signs were placed in the reception area of the lobby, break area, and waiting rooms of the inpatient and outpatient areas noting the contact information for addressing complaints for the California Department of Public Health.	10/15/2018 10/15/2018

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A 117	Continued From page 7 phone number to which to report complaints regarding patient care; she stated the appropriate changes would be forthcoming. 2. Review of Patient 15's admission record indicated the patient was eight years old when admitted. On 8/2/2018 at 11:25 a.m., during an interview and concurrent review of patient medical records, the director of quality management confirmed the signatures on the "Rights of Patients" and Acknowledgement of Receipts: Notice of Privacy Practices". The director indicated hospital staff should inform and obtain signature from the legal guardian of an underage patient.	A 117		
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to inform the patient (Patient 3) of a proposed antipsychotic medication (those in a class of psychiatric drugs used to treat major illnesses such as schizophrenia and bipolar disorder. They work to reduce delusional thought,	A 131	A131 PLAN OF CORRECTION: 1) In-service staff on policy of informed consent and involvement in Treatment Plan. 2) Consent will be kept with the MAR. 3) In-service with pre/post test during shift change. 4) Chart audits on NOC shift daily. 5) Will maintain a log and evaluate audit results by Nurse Manager.	11/13/2018

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A 131	Continued From page 8	A 131		

hallucinations, and physical/emotional overactivity) thus decreasing the patient's involvement in his plan of care.

Findings:

During a record review of Patient 3's file, the "[Facility Name] Consent to receive psychotropic medications" indicated the patient had consented (agreed to treatment) on 6/22/18 to take the following medications: Latuda (antipsychotic medication used to treat schizophrenia and bipolar disorder), Ativan (typically used to treat anxiety and sleeplessness), Restoril (used for insomnia or panic disorder). There was no evidence of consent for the medication Seroquel.

A review of physician orders for Patient 3 showed an order was written on 6/22/18 for Seroquel 100 milligrams (mg) by mouth (PO) at bedtime (qhs).

The Medication Administration Record (MAR) for this patient on 6/22/18 revealed that he had been given Seroquel 100 mg PO at 21:00 on 6/22/18.

In a brief discussion with the Charge Nurse on 8/1/18 at 9:00 AM, he attested that the medication Seroquel should have been listed on the patient's consent to treat form.

According to [Facility Name] Policy and Procedure "Informed Consent to Antipsychotic Medications", a voluntary patient shall give consent to receive psychotropic medications only after being informed of the patient's right to accept or refuse treatment with the proposed medication as well as the benefits and side effects of the medication.

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A 144	Continued From page 9	A 144		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)	A 144		

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure a safe environment is provided for patients, by failing to:

1. Ensure the facility was free from ligature risk (anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation) in patient care areas, which had the potential to result in patient self- harm or death.

2. Ensure incident reports and investigations of the reports were completed, and ensure there was coordination of the reports by Security Staff and facility staff. This failure had the potential to result in incomplete investigations of adverse events.

Findings:

1. On 8/3/18 at 9:25 a.m., an observation of the Employee Bathroom in the Children's Inpatient Unit (CIP), located across from the Nurses Station, revealed a drain pipe on the toilet, and a U-pipe on the sink. The door was partially open, and did not have a security lock.

When questioned, RN 5 stated there was always a staff member in the Nurses Station who would be able to monitor the restroom.

On 8/3/18 at 9:40 a.m., an observation of the

1. Weekly CQI tracers are conducted to ensure that patient care areas are free of ligature and other environmental risks. In addition, all EOC related incident reports are required to complete an environmental risk assessment as a part of the investigation process. 8/27/2018

2. All incidents are reported within 24 hours of incident identification in accordance with local policy (Attachment C). The Patient Safety Manager, Risk Manager, and/or Director of Facilities Management are notified of the respective incident for immediate follow-up action/investigation. All incidents are tracked and categorized by the severity and/or complexity of the incidents (Attachment C) and further analysis is conducted (i.e. RCA) if deemed necessary. Once investigations are completed they are closed out accordingly and monthly reports are given at the QAPI and Risk Management Meetings, MEC, and Governing Board. We are currently in the process of going to an Electronic Patient Safety Reporting System (PSR), which will eliminate the paper reporting system and allow the investigation process to be more efficient. In addition, this will increase reporting and allow us to be able to print various reports. 8/27/2018

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A 144	Continued From page 10 Adult Outpatient Male and Female Rest Rooms also indicated there were regular drain pipes on the toilets and sinks. On 8/3/18 at 3:20 p.m., during an interview with the Safety Director, he stated he was not aware of the ligature in the restrooms, and that the facility did not have a policy that addressed ligature risk. 2. On 8/1/18, a review of Reports provided by the facility indicated the reports were being submitted by both Security Staff and the facility staff. Some of the reports were not completely filled out, and did not indicate investigation outcomes. a) A Report, dated 7/2/18, and completed by a Case Manager, indicated Patient 43 (on the Children's Inpatient Unit) had alleged that a mental health worker (MHW) had choked him. The patient's room number, age, reason for hospitalization, time the Case Manager was notified, and whether the patient was seen by a physician, had been left blank. The report indicated the patient's physician was notified. However there was no further information regarding whether the alleged perpetrator was interviewed, or the final outcome of the investigation. b) A Report dated 6/28/18 and completed by a registered nurse (RN), indicated Patient 44's family member had called and stated that Patient 44 had told him she had been sexually assaulted by her roommate. The family member also stated that he had called the prior night and had spoken to another staff member regarding his concern for Patient 44's safety. The report further indicated that the family member expressed concern for	A 144	A144 PLAN OF CORRECTION: 1) Request all code locks on all staff bathrooms. 2) Follow-up with Engineering Department 3) Nursing staff will escort patients to bathroom if needed. 4) Staff will check bathroom door to ensure it is locked. All staff will monitor every shift.	11/13/2018

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A 144	Continued From page 11 Patient 44's safety to the RN, and requested that she be transferred to another room. Further review of the incident report indicated that the RN had assured the family member that the patient was safe, and would report the family member's concerns to the supervisor. The section of the report that addressed whether the physician was notified, and whether the patient was seen by a physician, were both checked "No." The signature of the RN who completed the report was illegible. There was no indication of further investigation by the facility. On 8/1/18 at 10:45 a.m., during an interview, the Director of Quality Assurance (QA) was asked regarding how reports were handled. The Director stated she has been at the facility just over a month, and that there was no one in the position for the prior year. She also stated that there is no Patient Safety Manager or a Risk Manager. The QA Director then stated she has been trying to implement a method for handling the reports she receives from security staff and floor staff, and was not sure if the reports had been investigated yet. She added that there was no system to indicate whether the reports were still open, or if they had already been investigated.	A 144	We now have a full-time Patient Safety Manager on staff. All incidents are tracked and categorized by the severity and/or complexity of the incidents and further analysis (Attachment C) is conducted (i.e. RCA) if deemed necessary. Once investigations are completed they are closed out accordingly and monthly reports are given at the QAPI and Risk Management Meetings, MEC, and Governing Board. We are currently in the process of going to an Electronic Patient Safety Reporting System (PSR), which will eliminate the paper reporting system and allow the investigation process to be more efficient. In addition, this will increase reporting and allow us to be able to print various reports and see which reports are open, pending, and closed.	8/27/2018
A 175	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.	A 175		

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A 175	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to follow accepted practice with regard to monitoring patients who were under restraint. Assessment and monitoring should be performed to prevent injury to the patient and ensure the restraint can be discontinued as soon as possible. Findings: According to an "Emergency Psychoactive Medication Physician Order Form" completed for Patient 21 on 7/29/18 at 06:20, the following medications were ordered and validated by the physician on 7/29/18: Haldol, Benadryl, Ativan; each medication was to be given one time for signs of agitation. The "Emergency Use of Medications Assessment Flowsheet" asserts that the patient should be monitored and monitoring documented every 15 minutes after administration of restraint. There was no apparent documentation for this incident in the patient's file. During a short conversation with the Charge Nurse on 8/2/18 at 11:40 AM, he acknowledged that there should be documentation of this monitoring. A review of the facility's policy and procedure titled, "Seclusion and Restraint Use" (page 5 of 7) stipulated that a licensed staff member who is trained and competent in the use of restraints must assess the patient at the initiation of the restraint use and every 15 minutes thereafter in order to assess the needs and physical condition of the patient during this time.	A 175	A175 PLAN OF CORRECTION: 1) In-service staff on Seclusion and Restraints Policy regarding every 15 minute monitoring and documentation. 2) Pre/Post testing for Seclusion and Restraints Policy documentation, and Denial of Rights. 3) Audit daily on NOC shift Seclusion and Restraints, Denial of Rights, and Emergency Med List. 4) Nurse Manager will evaluate audits and provide feedback. (Attachment R)	08/26/2018 & 09/16/2018

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A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the hospital failed to establish and maintain a hospital-wide, data-driven QAPI program to ensure quality of care and patient safety. The facility did not meet the Condition of Participation in quality assurance and performance program by failing to: 1. Establish and maintain a hospital-wide quality assurance and performance improvement (QAPI) program to ensure quality of care and patient safety. There was no ongoing program that shows measurable improvement in indicators and program data for which there is evidence that it will improve health outcomes. (Refer to A 0273) 2. Establish and maintain a hospital-wide quality	A 263	1. The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment D).	7/24/2018

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A 263	Continued From page 14 assurance and performance improvement (QAPI) program to ensure quality of care and patient safety. There was no QAPI program data for the hospital to identify opportunities for improvement and setting of priorities for its performance improvement activities. (Refer to A 0283)	A 263	2. The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment D).	7/24/201
A 273	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment D).	7/24/2018
	This STANDARD is not met as evidenced by: Based on interview and record review, the			

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A 273	Continued From page 15 hospital failed to establish and maintain a hospital-wide quality assurance and performance improvement (QAPI) program to ensure quality of care and patient safety. There was no ongoing program that shows measurable improvement in indicators and program data for which there is evidence that it will improve health outcomes. Findings: An interview was conducted on 8/2/18 at 3:50 p.m., with the Director of Quality Management. When requested to provide the minutes of the QAPI Committee, the Director of Quality Management was unable to produce the documents, stating that the committee does not yet exist. She reported that her position had remained vacant since the previous director left about two years ago, and no definable QAPI program was in place at the hospital when she first arrived just over a month ago. She added that she has recently developed a QAPI plan, and has begun the process of training the staff in each department on determining quality indicators and gathering data. The Director subsequently furnished a document titled, "[Facility name] Health QAPI Program - Resource Guide" dated 7/5/18. Review of the document indicated an outline that defines the structure and components of the QAPI program in general.	A 273	The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment D).	7/24/2018
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement.	A 283	The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment C). Currently there are two PI activities starting based on QAPI data collected. PI charters are attached. (Attachment D).	7/24/2018

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A 283	Continued From page 16	A 283		

(c) Program Activities
(1) The hospital must set priorities for its performance improvement activities that--
(i) Focus on high-risk, high-volume, or problem-prone areas;
(ii) Consider the incidence, prevalence, and severity of problems in those areas; and
(iii) Affect health outcomes, patient safety, and quality of care.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

This STANDARD is not met as evidenced by:
Based on interview and record review, the hospital failed to establish and maintain a hospital-wide quality assurance and performance improvement (QAPI) program to ensure quality of care and patient safety. There was no QAPI program data for the hospital to identify opportunities for improvement and setting of priorities for its performance improvement activities.

Findings:

Interview conducted on 8/2/18 at 1530 hours with the Director of Quality Management. When requested to provide the minutes of the QAPI Committee, the Director of Quality Management was unable to produce the documents, stating that the committee does not yet exist. She reported that her position had remained vacant

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A 283	Continued From page 17 since the previous director left about two years ago, and no definable QAPI program was in place at the hospital when she first arrived just over a month ago. She added that she has recently developed a QAPI plan, and has begun the process of training the staff in each department on determining quality indicators and gathering data. The Director subsequently furnished a document titled "[Facility Name] Health QAPI Program - Resource Guide" dated 7/5/18. Review of the document indicated an outline that defines the structure and components of the QAPI program in general.	A 283	The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment D).	7/24/2018
A 297	QAPI PERFORMANCE IMPROVEMENT PROJECTS CFR(s): 482.21(d) As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are	A 297	Currently there are two PI activities starting based on QAPI data collected. PI charters are attached (Attachment D). Evidence of standard compliance will be monitored by CQI on a monthly basis and reported to the QAPI and Risk Management Committee; MEC; and Governing Board.	09/27/2018

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A 297	Continued From page 18 required to be of comparable effort. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital as part of its quality assessment and performance improvement (QAPI) program failed to have documentation what quality improvement projects are being conducted to ensure quality of care and patient safety. There were no QAPI projects for review. Findings: An interview was conducted on 8/2/18 at 15:30 p.m. with the Director of Quality Management. When requested to provide the minutes of the QAPI Committee, the Director of Quality Management was unable to produce the documents, stating that the committee does not yet exist. She reported that her position had remained vacant since the previous director left about two years ago, and no definable QAPI program was in place at the hospital when she first arrived just over a month ago. She added that she has recently developed a QAPI plan, and has begun the process of training the staff in each department on determining quality indicators and gathering data. The Director subsequently furnished a document titled "[Facility Name] Health QAPI Program - Resource Guide" dated 7/5/18. Review of the document indicated an outline that defines the structure and components of the QAPI program in general. In the interview on August 3, 2018 starting at 9:12 AM, both registered dietitians (RD1 and RD2)	A 297	The QAPI program was implemented upon the Director of Quality Management's arrival which was June 18, 2018. The first meeting was held on July 24, 2018. Meetings are held every fourth Thursday of the month. (Attachment D).	7/24/2018

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A 297	Continued From page 19 indicated they currently do not have any performance improvement projects going on and did not develop any in the past. RD 1 stated her monthly audits are presented to the administrator and director of food services. A review of the facility document titled "Sanitation Report" completed monthly by RD 1 from November 2017 through April 2018 showed poor labeling as one of the identified concerns. Most of the other deficient practices identified during the survey were however, not identified by RD 1.	A 297	Currently there are two PI activities starting based on QAPI data collected. PI charters are attached. Including one from Dietary Services. Evidence of standard compliance will be monitored by CQI on a monthly basis and reported to the QAPI and Risk Management Committee; MEC; and Governing Board.	09/27/2018
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure a registered nurse would assess each patient on admission to develop and implement appropriate care plan that meet the patient's need (Patient 31). Findings: Review of Patient 31's admission record indicated Patient 31 was admitted on 7/23/2018 and was transferred from another general acute care hospital (GACH). Review of a laboratory report from the previous GACH indicated that on 7/22/2018, a day before this hospital admission, Patient 31 had skin rash confirmed to be scabies (a contagious skin condition caused by an infestation of mites). On 8/3/2018 at around 2:10 p.m. during a concurrent interview with the chief of nursing	A 395	A395 PLAN OF CORRECTION: 1) In-service Registered Nurses on Admission Procedure and Documentation regarding Care Plan meeting patient needs. 2) In-service pre/post test regarding Admission Documents, skin assessment and signs and symptoms of contagions skin infestations. 3) Audit daily on NOC shift audit documentation, Plan of Care for assessment or treatment of contagions skin conditions. 4) Nurse Manager will evaluate audits and provide feedback.	11/06/2018

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A 395	Continued From page 20 (CON), CON confirmed that Patient 31's physician orders and interdisciplinary plan of care did not indicate an assessment nor a treatment plan for Patient 31's contagious skin condition.	A 395		
A 431	MEDICAL RECORD SERVICES CFR(s): 482.24 The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital. This CONDITION is not met as evidenced by: Based on observation, interview, and record review the facility failed to meet the Condition of Participation for Medical Record Service by failing to: A. Ensure a patient's clinical record (Patient 15) contained an accurate description of the patient's reconciliation of personal belongings before he was discharged from the facility. (Refer to A-0438) B. Include a completed Discharge Summary in Patient 17's clinical file; verify that the record of Patient 19 contained complete, legible, and authenticated orders. (Refer to A-0450) C. Make sure that patients' medication orders (Patients 11-15, 17-18, 23) were promptly authenticated by the prescribing physician. (Refer to A-0454) D. Verify that a properly executed informed consent form of Patient 31 for use of an antipsychotic medication was initiated by the	A 431		

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A 431	Continued From page 21 prescribing practitioner. (Refer to A-0466) The cumulative effect of these systemic problems resulted in increased probability of medication errors and/or patient safety.	A 431		
A 438	FORM AND RETENTION OF RECORDS CFR(s): 482.24(b) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure patient's medical record was accurately written (Patient 15). Findings: On 8/1/2018 at around 4 p.m. during an inspection of the hospital's night locker (a medication storage area designated for after-hour access, after the pharmacy is closed) in the presence of the director of pharmacy (DOP), there were two drawers with signage indicating the drawers may contain patients' own medications or medication brought from home upon admission. Inside one of those drawers, there was a sealed paper bag marked with Patient 15's name. Review of Patient 15's medical record indicated	A 438	All patient medical record entries must be legible, complete, dated, times, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Medical records staff routinely audits charts identifying deficiencies based on an established audit criteria. The deficiencies are flagged and the percentage of non-compliance deficiencies are noted in a monthly report to Quality Assurance. These non-compliance findings will be reported monthly to the Medical Director and Director of Nursing of the AIP hospital unit. Along with copies of the issues identified as non-compliance. A Medical Records Review Guideline Tool was implemented on 10/19/18 to ensure records were complete, legible, and authenticated in accordance with local policy, state and federal regulatory standards. (Attachment E)	10/19/2018

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A 438	Continued From page 22 Patient 15 had been discharged on 7/17/2018. Review of Patient 15's Interdisciplinary Discharge Summary dated 7/17/2018 at 4:05 p.m. revealed an entry by a registered nurse stating "Patient discharged with all personal belongings." (Cross reference A 500)	A 438		
A 450	MEDICAL RECORD SERVICES CFR(s): 482.24(c)(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to make certain that patient's medical record (Patient 19) contained complete, legible, and authenticated orders. The hospital also failed to ensure Patient 17's Interdisciplinary Discharge Summary was completed. Findings: 1. During a record review of Patient 19's file, physician admission orders were taken by telephone by a registered nurse and written 6/21/18 at 7:25 PM. The admitting diagnosis for this patient was unspecified psychosis. Among the medications ordered upon admission were the following: Ativan (medication typically used to control anxiety or sleeplessness), Restoril (used to treat sleeplessness), and Geodon (atypical antipsychotic medication that treats schizophrenia and bipolar disorder. There was no	A 450	All patient medical record entries must be legible, complete, dated, times, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Medical records staff routinely audits charts identifying deficiencies based on an established audit criteria. The deficiencies are flagged and the percentage of non-compliance deficiencies are noted in a monthly report to Quality Assurance. These non-compliance findings will be reported monthly to the Medical Director and Director of Nursing of the AIP hospital unit. Along with copies of the issues identified as non-compliance. A Medical Records Review Guideline Tool was implemented on 10/19/18 to ensure records were complete, legible, and authenticated in accordance with local policy, state and federal regulatory standards. Individual Responsible: Medical Records Supervisor Monitoring/Tracking Procedure: Monthly QAPI Tool: AIP/CIP Medical Records Chart Review Form (Attachment E)	10/19/2018

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A 450	Continued From page 23 documentation showing the ordering physician authenticated these orders. A subsequent order for this same patient on 6/21/18 at 7:58 PM indicated that an order for open seclusion along with cuffs/anklets restraints were to begin 6/21/18 at 7:50 PM and end 6/21/18 at 11:50 PM. There was no indication that the ordering physician had signed the orders. During a brief conversation with the Charge Nurse on 8/2/18 at 1205 PM, he stated that the orders should have been signed within 48 hours of the origination of the order. According to the "[Facility Name] Policies and Procedures - Medication Administration", telephone or verbal orders are to be written only by authorized personnel for emergency situations; such orders should be documented in the patient's progress notes and these orders countersigned by the ordering physician within two (2) working days. 2. During a review of closed records, Patient 17's Interdisciplinary Discharge Summary (paper form) was blank. On 8/3/2018 around 2:10 p.m., the Chief of Nursing (CON) presented a printout of the electronic version of the aforementioned form which indicated two of six disciplinary services; nursing and rehabilitation services, had made an entry each. However, the other four services were blank, including psychiatric, psychological, and social services. During a concurrent interview, the CON indicated the interdisciplinary discharge summary should	A 450	The Medical Records Supervisor will implement and monitor training staff on the importance of auditing the date / time/MD sign noted on all orders. Implemented on 10/16/18 ,with Revised Medical Record Chart Audit Tool (Attachment D), the Director of Rehabilitation has provided a list of the AIP Interdisciplinary Treatment Teams to assist Medical Records in identifying when missing/not completed/ signed Treatment plans who should be informed of the non-compliance deficiency. This will ensure treatment is clearly documented and signed by all disciplines. In addition, emails will be sent to disciplines responsible and courtesy copied to Medical Director,Director of Nursing, Director of Rehabilitation and Director of Social Services. Monitoring/Tracking Procedure: Bi-weekly audit of staff work. Director of Rehabilitation has provided a list of the AIP Interdisciplinary Treatment Teams to assist Medical Records in identifying when missing/not completed/no signature who should be informed of the deficiency. This will ensure treatment plans are clearly documented and signed by all disciplines. Emails will be sent to disciplines responsible and carbon copied to Medical Director, Director of Nursing, Director of Rehabilitation and Chief of Social Services. Individual Responsible: Medical Records Supervisor	10/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 450	Continued From page 24 have been completed prior to the patient's discharge. Patient 17 was discharged on 7/26/2018.	A 450	Adult Inpatient Treatment Teams Tool implemented on 10/16/18	10/16/2018
A 454	CONTENT OF RECORD: ORDERS DATED & SIGNED CFR(s): 482.24(c)(2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the hospital failed to ensure medication orders were authenticated and/or signed by the prescribing practitioner promptly (Patients 11, 12, 13, 14, 15, 17, 18, 23, 9, 10, 35 and 36). This deficient practice had a potential for medication errors and/or patient safety. Findings: 1. Review of Patient 11's physician admission order dated 7/27/2018 at 6:20 a.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. 2. Review of Patient 12's physician admission order dated 7/21/2018 at 6:42 p.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. 3. Review of Patient 13's physician admission order dated 6/24/2018 at 6:30 p.m. indicated it	A 454	Content of Record: Orders Dated & Signed. Medical Records Clerk will/review chart on unit for signatures/and flag for physicians signatures. Clerk will also inform charge nurse of missing signature. If after 3 days and still no signature Medical Director and Director of Nursing will be informed. This process will be implemented on 10/22/2018. A QAPI measure has been put in place to track and trend improvement in this area. Monitoring/Tracking Procedure: Bi-weekly review Individual Responsible: Medical Records Supervisor 1. Appropriate disciplinary action will be taken by the MEC pending peer review. 2. Appropriate disciplinary action will be taken by the MEC pending peer review. 3. Appropriate disciplinary action will be taken by the MEC pending peer review.	10/22/2018 10/26/2018 10/26/2018 10/26/2018

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A 454	Continued From page 25 was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. 4. Review of Patient 14's physician admission order dated 6/12/2018 at 8:35 p.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. 5. Review of Patient 15's physician admission order dated 7/6/2018 at 8:10 p.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. Patient 15 was discharged on 7/17/2018. 6. Review of Patient 17's physician admission order dated 7/19/2018 at 1:00 a.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. 7. Review of Patient 16's physician admission order dated 7/19/2018 at 9:30 p.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. 8. Review of Patient 23's physician admission order dated 7/22/2018 at 6:55 p.m. indicated it was a telephone order and the prescriber had not authenticated the order as of 8/1/2018. On 8/2/2018 at 9:40 a.m. during an interview, the chief of nursing (CON) indicated the prescribers should sign the orders within 24-48 hours. Review of the hospital policy and procedure, Verbal/Telephone Orders, last reviewed in 4/2018, indicated " ...Orders that are not written by a prescriber (e.g., verbal or telephone) shall be subsequently authenticated (verified) and countersigned by the prescribing practitioner ...	A 454	4. Appropriate disciplinary action will be taken by the MEC pending peer review. 5. Appropriate disciplinary action will be taken by the MEC pending peer review. 6. Appropriate disciplinary action will be taken by the MEC pending peer review. 7. Appropriate disciplinary action will be taken by the MEC pending peer review. 8. Appropriate disciplinary action will be taken by the MEC pending peer review.	10/26/2018 10/26/2018 10/26/2018 10/26/2018 10/26/2018

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A 464	Continued From page 26 within 48 hours. The prescribing practitioner must enter signature, date, and time authenticating the order." 9. Review of of the closed record for Patient 9 indicated a telephone order for lice-killing shampoo, dictated on 6/20/18 at 1800 [6 p.m.], was signed by the physician but not dated and timed. In the physician's orders for Lithium and Zyprexa, written on 6/21/18 at 1658 [4:58 p.m.], route of administration was omitted. Informed consent for treatment with psychotropic drugs was not completed. 10. Review of the closed record for Patient 10 indicated a telephone order for Haldol, Ativan, and Benadryl, dictated on 6/17/18 at 1000 hours, was signed and dated by the physician but not timed. Physician's telephone order to discharge the patient, dictated on 6/22/18 at 0900 hours, was not authenticated. Emergency psychoactive medication physician order, dictated on 6/17/18 at 1030 hours, was not authenticated. 11. Review of Patient 35's medical record on 8/3/18 indicated a telephone order for renewal of Ativan and Restoril, dictated on 8/1/18 at 0800 hours, was signed by the physician but not dated and timed. Physician telephone order for renewal of Ativan and Restoril, dictated on 7/25/18 at 0800 hours,	A 454	9. Appropriate disciplinary action will be taken by the MEC pending peer review. 10. Appropriate disciplinary action will be taken by the MEC pending peer review. 11. Appropriate disciplinary action will be taken by the MEC pending peer review.	10/26/2018 10/26/2018 10/26/2018

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A 454	Continued From page 27 was not authenticated. 12. review of Patient 36's medical record indicated a telephone order for Ensure, dictated on 7/30/18 at 1915 [7:15 p.m.], was not authenticated. Physician Admission Orders, dictated on 7/27/18 at 1715 hours, were not authenticated. According to the Medical Staff "Rules and Regulations, Section 6.5 Clinician Orders", dated October 2014, "Orders dictated over the telephone shall be signed by the person to whom dictated per the name of the Clinician, indicating the time and date the order was given. Telephone orders for medications, restraints and seclusion must be signed by the attending psychiatrist or consulting physician, as appropriate, within 24 hours, all other telephone orders must be signed within 48 hours."	A 454	A466 Content of Record: Informed Consent. Medical records in auditing will review consent forms more thoroughly to ensure procedures and treatments specified by the medical staff have the necessary signatures. If not signed will be forwarded to the Medical Director. Individual Responsible: Medical Records Supervisor Monitoring/Tracking Procedure: Bi-weekly audit Tool: Medical Records Chart Audit Tool (Attachment E).	
A 466	CONTENT OF RECORD: INFORMED CONSENT CFR(s): 482.24(c)(4)(v) [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the hospital failed to ensure prescribing practitioner complete an informed consent for the use of an antipsychotic medication on Patient 31.	A 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 466	Continued From page 28 Findings: Review of Patient 31's physician's orders indicated an order of Invega Sustenna (a long-acting antipsychotic medication indicated for the treatment of psychiatric conditions) 234 milligrams intramuscularly (into the muscle). This order was dated on 8/1/2018 at 11:30 a.m. Review of Patient 31's Medication Consent for Atypical Long-Acting Anti-Psychotics form, dated 8/1/2018, did not include the medication name and dosage. On 8/3/2018 at 2:10 p.m. during a concurrent interview, the chief of nursing confirmed the antipsychotic consent should be filled out completely with the name and dosage of the medication prescribed.	A 466		
A 600	DELIVERY OF DRUGS CFR(s): 482.25(b) §482.25(b) Standard: Delivery of Services In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observation, interview, and record reviews, the hospital failed to: 1. Ensure the pharmacy and therapeutics committee (P&T, a committee that would be responsible for the establishment and evaluation of a safe and effective system in the use of .	A 600	1. The P&T Committee will be held in accordance with local policy. Memorandums will be sent to those individuals that are expected to attend. This will be mandatory attendance.	

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A 500	Continued From page 29 medications and chemicals) would be held as per policy. 2. Ensure its policy and procedure accurately described the current process of medication dispensing. 3. Ensure discharged medication dispensed by a retail pharmacy would be returned if the patients were not discharged within seven days. 4. Ensure patient's own/home medications be returned to the patient on discharge. Findings: 1. On 7/31/2018 at 12:55 p.m. during an interview, and a concurrent review of the hospital's P&T committee records for the past twelve months, the director of pharmacy (DOP) confirmed the committee had met twice in the year of 2017 (on 3/24/2017 and 11/15/2017) and once thus far in 2018 (on 4/13/2018). The P&T records consisted of the agendas and exhibits presented at the meetings; however, the attendances and minutes for these past meetings were not readily available. Review of the hospital policy and procedure, Pharmacy and Therapeutics Committee, last reviewed in 4/2018, indicated "The Pharmacy and Therapeutics Committee exists as part of the Hospital Medical Staff. It is an advisory group of the medical staff ... The committee shall consist of at least three physicians, ... one pharmacist, the director of nursing service ..., medical staff secretary, and the administrator ... The recording of the meeting's minutes shall be the responsibility of the Medical Staff secretary and	A 500	2. Policy No. 6390.11.01 Dispensing General (Attachment F) and Policy No. 6390.11.06 After Hours Dispensing (Attachment G) was updated to reflect the organization's current process and procedures. This was distributed to all staff responsible for dispensing and handling medications on 10/18/2018. 10/18/2018 3. Nursing and Outpatient Pharmacy to meet on October 23, 2018, to address this, and develop a P&P. 10/23/2018 4. An in-service will be provided by the Inpatient Pharmacy Director to all Nursing Staff on 10/25/2018. 10/25/2018 1. The P&T Committee will be held monthly. The policy was updated to reflect this change. In addition, memorandums will be sent to those individuals that are expected to attend. This will be mandatory attendance. 10/19/2018	

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A 500	Continued From page 30 shall be maintained in the permanent records of the hospital. The committee shall meet at regular intervals, no less frequently than quarterly or four times per year ..." 2. On 7/31/2018 at 12:40 PM, during an interview, the director of pharmacy (DOP) stated the pharmacy hours were Mondays through Fridays from 9 am to 7 PM. The hospital had a night locker (a medication storage area designated for after-hour access, after the pharmacy is closed) and maintained floor stock at each nursing unit. On 8/1/2018 at around 4:30 PM, during an interview, the DOP stated the nursing usage logs of the after-hour night locker would be reviewed every Friday. Review of the hospital's After Hours Medication Room (night locker) Dispensing Log for the months of June and July in 2018 indicated there were at least thirty doses removed during the pharmacy hours. On 8/2/2018 at around 4 PM, during an interview, and concurrent review of the night locker dispensing log, the DOP acknowledged there were multiple doses removed by a licensed vocational nurses (LVN) and entries written in types of ink and/or penmanship different than the nurses' names. The DOP stated only a registered nurse should access and document medications removed from the night locker. The DOP also confirmed there were multiple doses removed during pharmacy hours, and many doses removed at the same time for multiple patients. The DOP acknowledged most of these doses were removed shortly before or after pharmacy hours. The DOP further confirmed the access to	A 500	2. The pharmacy hours are from 9:00 a.m. to 5:30 p.m. In addition, the hours are stated in the introduction of the Policies and Procedures. The hours are also posted next to our DEA license within the pharmacy. (Attachment H). If any of the 30 doses mentioned were removed between the hours of 5:30 p.m. and 7:00 p.m., they are not removed incorrectly. To address any removal of medication that could have still been removed during pharmacy hours, a memorandum was distributed to the nursing staff on 9/24/2018 at 3:12 p.m. (Attachment I). This memorandum addressed the fact that only authorized RNs are permitted to enter and remove medications from the night locker. The DON has also addressed this with the staff and has fully reviewed and updated the list of authorized RNs. In addition, we will be holding a Nursing Training on 10/25/2018, which will address this as well. In regards to the LVN, mentioned by the surveyor, appropriate disciplinary actions have been taken in accordance with local policy. In addition, a meeting has been scheduled with Becton Dickinson for 10/16/2018 to discuss a Pyxis	09/24/2018 & 10/25/2018

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A 500	Continued From page 31 the night locker should be limited to after hours and for immediate use; there were overlapped medication storage in the floor stock and the night locker. Review of the hospital policy and procedure, After Hour Dispensing, last reviewed in 4/2018, indicated " ... The hospital shall established a supply of medications which is accessible without entering the pharmacy during hours when the pharmacist is not available. Access to the supplies shall be limited to designated registered nurses ... When medications are ordered for patients after pharmacy hours, the designated registered nurse should ... obtain the necessary medications from the after-hours medication room ... for the [patients'] immediate needs. The pharmacist shall reconcile all items removed from the After Hours Medication Room the next day to the physician's orders." Review of another hospital policy and procedure, Dispensing General, last reviewed in 4/2018, indicated " ... If the order is written when the pharmacy is "closed" ... it should be reviewed by a pharmacist as soon thereafter as possible, preferably within 24 hours, but not more than 72 hours following preparation and dispensing ..." 3. On 7/31/2018 at 2:45 PM during an inspection of the medication room at the Adult Inpatient nursing unit 1 (AIP-1), there were at least seven brown paper bags in a cabinet; each bag was individually labeled for different patients. Two of those bags (labeled for Patient 13 and 14 respectively) were dated at least ten days to a month prior. The labels on those brown bags indicated it was from a pharmacy named differently than the hospital.	A 500	Policy No. 8390.11.08 After Hours Dispensing (Attachment F) was updated to reflect the organization's current process and procedures. This was distributed to all staff responsible for dispensing and handling medications on 10/18/2018. 3. Nursing and Outpatient Pharmacy to meet on October 23, 2018, to address this, and develop a P&P. Inpatient Pharmacy will assist and must be involved in the development of the P&P. The agreement mentioned (Attachment J) must be reviewed and developed into a Policy and Procedure both in the Nursing and Pharmacy P&P manuals.	10/18/2018 10/23/2018

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A 500	Continued From page 32	A 500		

During a concurrent interview, the director of pharmacy (DOP) indicated those bags contained discharge medications dispensed by a retail pharmacy located within the hospital premises as a separate entity (not listed on the hospital license). The charge nurse in presence confirmed that both patients 13 and 14 were still inpatient at the hospital and had not been discharged.

On 7/31/2018 at 3 PM the charge nurse indicated once discharge planning started, the patient's physician would order discharge medications to the retail pharmacy. The retail pharmacy would dispense and deliver to the nursing unit. The charge nurse also indicated if there was a change to the discharge plan, or if the patient declined those medications upon discharge, their discharged medications would be returned to the retail pharmacy.

On 7/31/2018 at 4 PM the chief executive officer (CEO) of the hospital stated the outpatient (or retail) pharmacy was not part of the hospital. The hospital had an agreement with the retail pharmacy to dispense discharge medications for their patients upon discharge if their patients desired.

Review of the hospital policy and procedure, Discharge Drugs, last reviewed on 4/2018, indicated "The pharmacy shall NOT furnish drugs to patients upon release from the facility. The physician responsible for the patient shall provide the patient with a prescription that may be filled at [the hospital] out-patient pharmacy."

Review of the agreement between the hospital and the retail pharmacy, not dated, indicated if

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A 500	Continued From page 33 the hospital patient did not receive the discharge dispensed by the retail pharmacy after being discharged, the hospital staff would return the medications to the pharmacy within 7 days. 4. On 8/1/2018 at around 4 p.m. during an inspection of the hospital's night locker (a medication storage area designated for after-hour access, after the pharmacy is closed) in the presence of the director of pharmacy (DOP), there were two drawers with signage indicating the drawers may contained patients' own medications or medication brought from home upon admission. Inside one of those drawers, there was a sealed paper bag marked with Patient 15's name. On 8/1/2018 at 4:10 PM at the Children inpatient nursing unit, the charge nurse confirmed that Patient 15 had been discharged on 7/17/2018. Review of the hospital policy and procedure, Patients Own Medication, last reviewed in 4/2018, indicated the nursing supervisor would give the medications to the patient or their family upon discharge.	A 500	4. This will be addressed with Nursing and Policy and Procedure titled "Patients Own Medication".	
A 618	FOOD AND DIETETIC SERVICES CFR(s): 482.28 The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards	A 618	Corrective action will be accomplished for for this dietary service staffing by structuring the dietary department to include:a full time Food Service Director RD. will oversee all systems of dietary and clinical operations for all listed deficiencies and implement QAPI for Dietary Services In addition to 20 - 25 hrs consultant RD managing Pt assessment and therapeutic care At the present time, in addition to the current 40 hrs 2 consultant RD , the organization hired Food service RD for 10 hrs a week on consulting basis. (Attachment U)	11/15/2018

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 618 Continued From page 34

specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

This CONDITION is not met as evidenced by:
Based on observation, review of facility documents, manufacturers' instruction and staff interviews, the hospital failed to ensure that the hospital was directed and staffed by adequate qualified personnel to meet the nutritional needs of the patients in accordance with practitioners' orders and acceptable standards of practice. (Cross refer A619, A620, A621, A629, A630, A724, A749)

1. Failure to organize the food and nutrition services in a manner to meet the needs of the patients and appropriate to the scope and complexity of the service operations. (Cross refer A 619)

2. The person in the position of the director of food and nutrition services department who did not meet the educational requirements and training that met state law. (Cross refer A 620)

3. Failure to identify deficient food safety practices that resulted in an immediate jeopardy situation. (Cross refer A 620 and A 749)

4. Lack of a system to incorporate the services and expertise of a registered dietitian in the nutrition care of patients. (Cross refer A 620)

5. Inadequate provision of dietitian hours and consultation services that met the needs of the patients. (Cross refer A 621)

A 618 1. Corrective action will be accomplished for for this dietary service staffing by structuring the dietary department to include:a full time Food Service Director RD. will oversee all systems of dietary and clinical operations for all listed deficiencies and implement QAPI for Dietary Services. In addition to 20 - 25 hrs consultant RD managing Pt assessment and therapeutic care At the present time, in addition to the current 40 hrs 2 consultant RD , the organization hired Food service RD for 10 hrs a week on consulting basis. Restructuring Dietary Department to meet Dietary Department needs of patients. 11/15/2018

2. Organization plan to hire qualified Dietary manager and keep under the supervision of full time Food Service Director RD 11/15/2018

3-4. Currently , RD consultant is now a member of the Medical Executive Committee that include Medical Chief of Staff, Director of Education and Psychiatry , Director of Nursing, Director of Quality Management and Director of Medical Record Committee meets on monthly basis to review and ensure staff competency, QA/QI plans are followed and policy and procedures are in place. 09/10/2018

5. Corrective action will be accomplished for for this dietary service staffing by structuring the dietary department to include:a full time Food Service Director RD. will oversee all systems of dietary and clinical operations for all listed deficiencies and implement QAPI for Dietary Services In addition to 20 - 25 hrs consultant RD managing Pt assessment and therapeutic care At the present time, in addition to the current 40 hrs 2 consultant RD , the organization hired Food service RD for 10 hrs a week on consulting basis. Restructuring Dietary Department to meet Dietary Department needs of patients. 11/15/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054093	A. BUILDING _____ B. WING _____	09/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 618	Continued From page 36 6. Failure to provide adequate registered dietitian coverage to meet the needs of the patients. (Cross refer A 621) 7. Failure to collaborate with nursing services and other services to plan and implement patient care as necessary to meet the nutritional needs of the patients. (Cross refer A 621) 8. Lack of menu that meets the nutritional needs of the patients. (Cross refer A 629) 9. Failure to approve and analyze patient menus. (Cross refer A 629) 10. Lack of an effective system to evaluate the nutritional needs of patients that includes follow-up assessment of patients, current professional standards.(Cross refer A 630) 11. Failure to perform and document nutrition assessments according to current standards of practice. (Cross refer A621 and A630) 12. Lack of implementation of a system that ensures the proper food safety practices. (Cross refer A 749) 13. Lack of maintenance of food service equipment. (Cross refer A 724) 14. Failure to provide oversight of the food service operation and its director of food services who did not meet state educational requirements for the position. (Cross refer A 749) 15. Lack of a data driven quality assurance, performance improvement program. (Cross refer A 297)	A 618	6. Restructuring Dietary Department to meet Dietary Department needs of patients; Full-time DIRECTOR. 7. RD member of the Medical Executive Committee to collaborate with nursing and medical staff as necessary to meet patient nutritional needs. 8, 9. Company contracted with a professional credible menu production Nutricopia to provide, menus , nutrition analyzes, recipes. (Attachment M) 10, 11. New EMR Avatar will be in use by all disciplines 11/15/2018 that will promote and facilitate the involvement of IDT in pt plan of care, ie, assessment and pt follow up. This will incorporate current standards of practice in RD assessment. 12. Contracted food service RD put a plan for food service staff training , to include training and education , assessing staff competency, monitoring kitchen operation. 13. Maintenance records developed, checked on daily basis. 14. Director of food service RD will monitor kitchen activities on daily basis. 15. Online compliance tool implemented for food service staff (Includes QAPI)	

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	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 618	Continued From page 36 The cumulative effect of these systemic problems resulted in the inability of the hospital's food and nutrition services to direct and staff in such a manner to ensure that the nutritional needs of the patients were met in accordance with practitioners' orders and acceptable standards of professional practice. Therefore, the Condition of Participation for Food and Dietetic Services was not met.	A 618	Restructuring the Dietary Dept to include qualified staff provide training, education and should meet and ensure that the pt nutritional needs are met according to standard. (1-3)	
A 619	ORGANIZATION CFR(s): 482.28(a) Organization This STANDARD is not met as evidenced by: Based on observation, review of hospital documents, manufacturers' recommendation and staff interviews, the hospital failed to ensure the food and nutrition services was organized in a manner to meet the needs of the patients. Findings: During the survey from July 31 - August 3, 2018, several deficient practices were identified that could be directly related to the function of the organization of the department. These include: 1. The person in the position of the director of food and nutrition services department who did not meet the educational requirements and training that met state law. (cross refer A 620) 2. Inadequate provision of dietitian hours and consultation services that meets the needs of the patients. (cross refer A 621) 3. Lack of a system to incorporate the services and expertise of a registered dietitian in the nutrition care of patients.	A 619	Currently contracted with Food Service RD to ensure educational services and training in the Dept met the state law. Plan to hire a full time RD as Director of Food Service in addition to 20/25 hrs RD to meet the needs of patients. 1. Currently contracted with Food Service RD to ensure educational services and training in the Dept met the state law. Plan to hire a full time RD as Director of Food Service in addition to 20/25 hrs RD to meet the needs of patients. 2,3. Currently contracted with Food Service RD to ensure educational services and training in the Dept met the state law. Plan to hire a full time RD as Director of Food Service in addition to 20/25 hrs RD to meet the needs of patients.	08/20/2018 08/20/2018 08/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 619	Continued From page 37 4. Lack of menu that meets the nutritional needs of the patients. (Cross refer A 629) 5. Lack of an effective system to evaluate the nutritional needs of patients that includes follow-up assessment of patients, current professional standards. 6. Lack of implementation of a system that ensures the proper food safety practices. (cross refer A 749) 7. Lack of maintenance of food service equipment. 8. Lack of a data driven quality assurance, performance improvement program. According to the review of personnel record, the hospital's director of food services (DFS) was hired seven months earlier. In an interview on August 1, 2018 starting at 4:00 PM, the DFS explained that he had been hired based on his experience and not on the education experience required by state law. He further explained that he did not manage the day- to- day operation of the kitchen but was responsible for the administrative functions of the department including food ordering, attending meetings and doing payroll. The DFS had not completed the food safety course for managers. He did not ensure that all food service workers completed food safety course (food handlers) required by state law. The Policies and procedure manual did not reflect current food safety practices. The policy titled, "Receiving Food and Supplies" dated 4/26/17 under the subheading "Handling over-produced food, leftover food and extra food" states "over produced food which has not been on the steam table, may be stored for later use. The food services department saved food and failed to monitor the cooling.	A 619	(4-8) 4. Contracted with Professional RD vendor - Nutricopia (Attachment M) to provide menu for company Full time RD , Director of food service to monitor food service personals, day to day activities and develop quality assurance program (QAPI) Addressed in detail in staffing A618 RD, Director of Food Service oversight on P/p manual 08/03/2018 staff training sessions were conducted regarding leftover and extra foods , pre and post test results available in compliance Online folder. Training was completed on 8/3/2018 at 2:00 p.m. (Attachment N).	

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	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 619	Continued From page 38	A 619		

The hospital had hired two part-time registered dietitians (RD) to provide nutrition care to the patients and limited food service responsibilities. The RDs were not always available to provide patient care services. The hours the one of the RDs were scheduled were not customary. RD 1's hours was from 4:15 AM to 10 AM. At this time, most of the patients are asleep and most other healthcare providers, the interdisciplinary team are not available. There is no RD scheduled on Thursday, Saturday and Sunday. There was a "stat" order for a nutrition consult for Patient 40 on one of the days, the RDs were not present (not scheduled) in the hospital. The nutrition consult was not completed until the next day. Stat orders are orders that are carried out with urgency. The RD 2 in an interview on August 3, 2018 starting 9:12 AM stated she completed the assessment the next day, this happened after Patient 40 who lost 11 pounds in 2 weeks and was transferred out to the acute care hospital as a result of the weight loss and refusal to eat.

The department did not have policy that addressed when follow up assessments were conducted on patients. Patient 39 who was admitted for over seven months was never reassessed. RD 1 and 2 in an interview on August 3, 2018 acknowledged there was no policy and procedure that addressed reassessment of patients. Patient 39 demonstrated problems with chewing during meal observation on August 1, 2018. The RD had assessed Patient 39 in December 2017 as not having any problems with chewing and swallowing.

One of the responsibilities of the RDs is the

Now EMR charting program will ensure that patients assessment and follow up are documented within the policy and procedures of the Department.

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A619	Continued From page 39 approval of the menus under federal and State laws. The menus were not analyzed to ensure that it was adequate to meet the recommended daily values for the population served. The kitchen and cook were not provided with recipes to prepare dishes to ensure consistency in flavor, nutrients. The food service workers were also not provided with aprons to help protect the staff and patients from cross contamination. The food and nutrition services did not evaluate its services to improve services provided.	A619	Menus will provided by a contracted company Nutricopia , including nutrition analysis, recipes , production manual. Contracted Food Service RD is currently training food service employees on menu implementations. (Attachment N).	
A620	DIRECTOR OF DIETARY SERVICES CFR(s): 482.28(a)(1) The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents, manufacturers' recommendation and staff interviews, the hospital failed to ensure the director of food and dietetic services had the necessary training, experience and qualifications to manage the service appropriate to the scope and complexity of the service operations. This deficient practice resulted in poor food safety and sanitation practices that resulted in immediate jeopardy situation being declared on August 2, 2018. The director of food service did not:	A620		

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 620	Continued From page 40 1. Ensure safety practices for food handling including proper cool down, proper storage and food labeling. 2. Ensure that food service equipment was in good working order. 3. Ensure that staff had adequate resources to perform food service duties including recipes, food thermometers, aprons, garbage cans. 4. Ensure that the water temperature of faucet on the hand washing sink was appropriate for hand washing. 5. Ensure the hand washing sink and janitorial sink was installed in a manner to prevent cross-contamination of food and water sources. Findings: A review of personnel record indicated that the DFS did not have any of the educational training required by state law. California Health and Safety Code 1265.4 requires that a licensed health facility (hospital) who does not hire a full time registered dietitian shall employ a full -time dietary services supervisor who meets some educational requirements. The requirements outlined include: (b)(1) a baccalaureate degree with major studies in food and nutrition, dietetics or food management and one year of experience in a licensed health facility (2) a graduate of a dietetic technician training program approved by the ..... (3) a graduate of a dietetic assistant training program approved.. (4) a graduate of a dietetic services training program approved by the Dietary managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains Certification ..... (5) a graduate of a college degree with major studies in	A 620	1-4. Implemented weekly "Kitchen Sanitation/Food Storage logs. In addition, and in-service on Food Labeling and Dating was provided to staff on 9/14/2018. (Attachment O).	09/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 620	Continued From page 41 food and nutrition, dietetics, food management, culinary arts, or hotel management and is a certified dietary manager (6) a graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision .... (7) Received training experience in food service supervision in the military ...." The Director of Food Service (DFS) stated that he did not have any of the outlined educational training and or experience. He stated in an interview on August 1, 2018 starting at 4:00 PM, he was hired based on his decades of experience in the food service industry not on educational achievements. Inside the walk in refrigerator on July 31 at 11:45 AM, there were several containers of food that were leftover food from previous meals stored on the second shelf. There was a container of cooked rice dated 7/30, a container of ham also labeled 7/30. There was gravy in a container dated 7/29, a container labeled meatballs dated 7/26. There was also a large 6- quart container labeled Spanish rice filled almost to the brim. There was a 20 lb. box of peas stored on the lower shelf in the refrigerator with manufacturer's instructions to "Keep frozen until ready to Cook". The observation was shared with DFS at 11:48 AM. A request for cooling logs was made to evaluate whether the items were cooled appropriately. DFS stated in the interview on July 31, 2018 at 11:48 AM, there were no cooling logs because the hospital not save leftover items. On August 1, 2018 at 10: 25 AM, there were leftover items observed stored on the top shelf in	A 620	RD consultant , food service, providing in service to dietary staff followed by competency evaluation was hired on August 20, 2018. Tools , logs have been created to monitor kitchen activities RD consultant for food service continue to offer training class on areas of deficiency.	08/20/2018

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A 620	Continued From page 42 the refrigerator. There was sally mashed potato dated 7/26/18, diced potato dated 7/12/18, beans dated 7/23/18, red potatoes dated 7/12/18, rice dated 7/29/18 another container of rice dated 7/30, garlic potatoes 7/26. Cook 1 stated he believed there was a 3- day grace period to use leftover items and they do not monitor or use any logs. Cook 1 stated he had not considered the lack of monitoring of cooling logs. The observation was shared with the DFS. The DFS stated on August 1, 2018 at 10:28 AM, the kitchen's priority was "to get breakfast and lunch out". The failure of the hospital to monitor proper cooling of food, lack of staff knowledge and system to implement the process and the lack of corrective action on the part of the DFS after it had been identified the day before created an immediate jeopardy (IJ) situation that had the potential to result in food borne illness. The IJ was removed (abated) on August 3, 2018 at 3:05 PM. During the tour of the kitchen on July 31, 2018 starting at 11:10 AM, during hand washing, the surveyor found the water temperature to be uncomfortably warm. There was no signage warning of the high water temperature. On August 1, 2018 at 10:20 AM during hand washing, the water temperature once again felt uncomfortably warm. In an interview with the DFS on August 1, 2018 at 11:00 AM about the high water temperature, DFS stated he was not aware that the water temperature was high and acknowledged the water temperature would not allow food service staff to wash their hands long enough (20 seconds) as recommended. The DFS	A 620	Consultant food service RD is addressing all deficiency stated in- services in progress by food service RD consultant. Temperature gauge was replaced on 8/27/2018. Logs are checked daily. Paper work at maintenance/ Engineering Dept. (Attachment P).	08/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 620	Continued From page 43 stated one of the registered dietitians (RD 1) had requested that water temperature be increased and so it was turned up by the facilities department. A temperature check of the water showed it as 126.1 degrees Fahrenheit (F). Warm water is more effective than cold water in removing the fatty soils encountered in kitchens. An adequate flow of warm water will cause soap to lather and aid in flushing soil quickly from the hands. High water temperature that makes hand washing uncomfortable may lead to poor handwashing practices by food employees. According to the 2017 Food Code Section 5-202.12 (A) "A handwashing sink shall be equipped to provide water at a temperature of least 100 degrees F through a mixing valve or combination faucet". ASTM Standards for testing the efficacy of handwashing formulations specify a water temperature of 100 to 108°F. American Society for Testing and Materials (ASTM) , is an international standards organization that develops and publishes voluntary consensus technical standards for a wide range of materials, products, systems, and services. Also attached to the faucet was an eye wash station. Higher water temperatures are harmful to the eyes and can enhance chemical interaction with the skin and eyes. In addition, the hand washing sink was located less than six inches from the drain board of the food preparation sink. There was no splash- guard preventing cross contamination of dirty soapy water from splashing on to food that may be prepared on the preparation sink. In the spice cabinet in the kitchen, there was an	A 620	Temperature gauge was replaced on 8/27/2018. Facility work order was placed to remove eye wash fixture and replace with regular faucet fixture to provide a constant water flow for hand washing to be in compliance. (Attachment Q).	08/27/2018 08/20/2018

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A 620	Continued From page 44	A 620		

opened one-gallon container of BBQ sauce dated "6/8/18". Manufacturer's recommendation stated "Refrigerate after opening". The food service manager present during the observation, stated on July 31, 2018 at 11:19 am, she was not aware that the sauce required refrigeration. FSM indicated that the date on the containers is the date received. FSW stated that they do not put date items were opened because they had been instructed by RD 1 to only put date the item was received. There were items such as spices, not labeled or dated.

There was no consistent labeling system. There were other items in the kitchen that had expiration dates and not dated when they were received. FSM who was present during the observation stated the errors may be due to new and agency employees that were recently hired who may have learned dating and labeling differently.

Inside the walk in freezer, there were item stored all the way to the roof of the freezer with very little clearance. The food items were stored very close to the fan on the condenser. The items were very tightly packed that poor air circulation was reduced. In an concurrent interview observation with the DFS at 2:03 PM, DFS indicated that the freezer space was limited.

At 1:52 PM on July 31, 2018, a large plastic measuring cup was observed stored in a storage container of flour. The FSM who was present during the observation removed the cup.

Equipment Maintenance
1. At 2:15 PM on July 31, 2018, the faucet in the 2-compartment sink was leaking hot water in the sanitizing compartment water. The constant

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A 620	Continued From page 45 dripping of the hot water into the solution had the potential to dilute the concentration, thereby making it ineffective. 2. At 2:47 PM, the temperature gauge for the dish machine was broken and temperature was stuck at 140 degrees F for both the wash and rinse cycles. Food service worker (FSW 3) who operated the machine stated the water temperature of machine is checked using a hand-held food thermometer. The temperatures are recorded while watching and listening to the different cycles. The FSM stated in a concurrent observation that she could not remember how long the thermometer had broken and when the food service staff started inserting a food thermometer in the water well to check water temperatures. The FSM flicked the temperature gauge with her finger, which moved the thermometer from 140 to 130 degrees F. The temperature gauge did not move after several wash cycles were observed. The process was unsafe due an increased the risk of burn as the water splashed as it was flowing and circulating the well. Review of the hospital document titled "(name of facility) Dishwasher Temperature Log" for the month July 2018 had a recording of 130 degrees F for the wash cycle (28 out of 31 days) for breakfast, 25 of 31 days for lunch and 27 of 31 days for dinner. For the final rinse cycle temperature of 140 degrees (F) was recorded 29 out of 31 days for breakfast, 29 out of 31 days for lunch 28 out of 31 days for dinner. According to the 2017 Food Code Section 4-602.11 (C) "Ambient air temperature, water pressure and water temperature measuring	A 620	Temperature gauge was replaced on 8/27/2018.	08/27/2018

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 620	Continued From page 46 devices shall be maintained in good repair and be accurate within the intended range of use." 3. There was water spewing out leaking from the faucet in the chemical storage/janitorial area outside the kitchen. Attached to the faucet was a two paired hose bib connection, the hoses were red and black in color. A hose bib(b) is a "threaded faucet also known as a wall hydrant". The end of the red hose was inside a blue bucket on the floor with a dark brown solution, with bubbles resembling soap or detergent. The connection did not have an anti-siphon or back-flow prevention device. There was a significant build- up of a brown colored substance on the rack adjacent to the faucet, resembling rust. There was a similar colored substance on the horizontal bracket that held the water pipe to keep the faucet in place. The presence of rust could be an indication of the presence continued moisture in the area. According to the 2017 Food Code Section 5-203.14. "a plumbing system shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the food establishment, including on a hose bibb if a hose is attached .... and backflow prevention is required by law, by: (a) providing an air gap as specified under § 5-202.13 or (b) installing an approved backflow prevention device ..." The facilities director in an interview on August 1, 2018 at 3:30 PM indicated he was not aware of the leaking of the faucet. In an interview with the FSD on August 1, 2018 starting at 4: 00 PM, the FSD indicated he made reports to the facilities department about the various equipment that	A 620	3. Facility work order was submitted to repair leaking faucet. (Attachment Q)	08/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	064083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 620	Continued From page 47 needed repairs. The FSD stated the reports were in form of email but was unable to provide evidence of the reports because he "does not keep email". Recipes There were observations with Cook 2 and Food service worker (FSW) 1 preparing food without recipes. Cook 2 prepared Cheese Enchilada Casserole without a recipe. FSW 1 was observed on July 31 and August 1, 2018 preparing fruit salad without a recipe. The lack of recipes was disoussed with the FSW on July 31, 2018 at 1:40 PM. The FSM in the interview stated that there were some recipes from the new menu cycle but the hospital did not have a complete set of recipes for all items prepared. The DFS stated in the interview on August 1, 2018 starting at 4:00 PM that the FSM was responsible for the kitchen and he was responsible for administration. Aprons During observations in the kitchen from July 31 through August 3, 2018, only three employees were observed wearing aprons as they performed food service duties. Other food service workers including those preparing food and helping with the assembly of meals did not wear aprons. In an interview with the group of food service workers on August 3, 2018 at 2:55 PM, a random FSW explained that the hospital does not provide them with uniforms and the expectation is that if they need aprons they will have to purchase the aprons themselves. FSW 3 who had an apron stated in an interview on August 1, 2018 at 2:15 PM, that he purchased the apron he had and takes it home to launder. Cook 2 who was also wearing an apron stated in an interview on August	A 620	Hospital contracted with a new company, Republic Uniform, to provide these services.	01/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 620	Continued From page 48 1, 2018 at 10:47 AM, that the hospital did not provide him with the apron. Cook 2 stated that the plastic apron melt when he gets close to the stove and heating equipment. The FSM who was present during the interview stated the hospital was "between vendors" and are currently not being provided with aprons. A review of the contracts between the previous and current laundry services provider, indicated that Contractor 1, (previous provider) provided kitchen towels, aprons, chef's coat, cook shirts and pants as part of the service (Exhibit B). A review of the contract for Contractor 2, (current provider) did not indicate if similar items were provided. There was a list of items as part of the contract but no aprons or kitchen towels were on the list. In an interview with the Laundry Supervisor (LS) on August 3, 2018 at 3:00 PM, LS acknowledged that the laundry services did not provide aprons. The lack of aprons for food service staff exposed the patients to possible cross contamination of food from clothing. Dirty clothing may harbor diseases that are transmissible through food. Food employees who inadvertently touch their dirty clothing may contaminate their hands. This could result in contamination of the food being prepared. Food may also be contaminated through direct contact with dirty clothing. (Food Code Annex) According to the 2017 Food Code Annex "All of the following control measures should be implemented regardless of the food preparation process used: ... ... Prevention of cross-contamination of ready-to-eat food or clean and sanitized food-contact surfaces with soiled	A 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 620	Continued From page 49 cutting boards, utensils, aprons, etc., or raw animal foods. A 621 QUALIFIED DIETITIAN CFR(s): 482.28(a)(2) There must be a qualified dietitian, full-time, part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on observations, review of hospital documents, clinical record review and staff interviews, the hospital failed to ensure that the contracted registered dietitians adequately supervised the nutritional aspects of patient care. The frequency of consultations did not meet the nutritional needs of the patients when registered dietitians failed to: 1. Approve and analyze patient menus. 2. Perform and document nutrition assessments according to current standards of practice. 3. Collaborate with nursing services and other services to plan and implement patient care as necessary to meet the nutritional needs of the patients. 4. Provide oversight of the food service operation and its director of food services who did not meet state educational requirements for the position. 5. Identify deficient food safety practices that resulted in an immediate jeopardy situation. 6. Provide adequate coverage to meet the needs of the patients. 7. Develop a quality assurance performance improvement program. Findings: A review of contracts showed that the hospital had entered into contracts with two dietitians (RD	A 620 A 621	1. Contracted with Professional RD vendor - Nutricopia (Attachment M) to provide menu for organization, Full time RD, and Director of Food Service to monitor food service personnels' day to day activities and develop quality assurance program (QAPI) Addressed in detail in staffing A618 2. New EMR will facilitate , and the availability of information to all involved will improve assessments and plan of care 3-7. Contracted with Professional RD vendor - Nutricopia (Attachment M) to provide menu for company Full time RD , Director of food service to monitor food service personnel, day to day activities and develop quality assurance program (QAPI) Addressed in detail in staffing A618	08/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 621	Continued From page 50	A 621		

1 and RD 2) to provide services "in the field of dietary and nutritional services". According to stipulations on the contracts, both RD 1 and RD 2 services' could each not exceed 20 hours per week.

In an interview with RD 1 on August 1, 2018 starting at 9:00 am, RD 1 indicated her work hours are from 4:15 am to 10:30 am, three days a week. RD 1 explained that RD 2 also works three days a week. Both RDs work the same two days (Mondays and Fridays) but their hours do not overlap. RD 1 also works on Wednesdays, while RD 2 works on Tuesdays. There is no RD coverage on Thursdays and weekends.

In the interview with RD 1 on August 1, 2018, RD 1 indicated that in addition to clinical nutrition responsibilities, she does a monthly inspection and audit of the kitchen. RD 1 indicated that she does in service education of the kitchen staff related to the menu. RD 1 further stated in the same interview that the hospital hired the RDs mainly for "patient care" and have no oversight of the kitchen and food service responsibilities.

An interview with RD 2 on August 3, 2018 starting at 9:12 am, RD 2 stated the hospital had limited the hours of services to no more than 80 hours a month and they could not exceed the hours.

Menu
There are no regulatory requirements for who can write or prepare a menu. However, there are regulatory requirements for menu approval of both regular and therapeutic diets by the registered dietitian. There was no notation that either RD 1 or RD 2 approved the menu. A review of the five-week hospital menu showed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 621	Continued From page 51 names of the two different RDs who prepared different weeks of the menu. RD 2's name was printed on two of the weeks as preparing the menu. The name of another RD (RD 3) was printed on some of the menus. The approval of the menu signifies that it has been reviewed and deemed appropriate in terms of the nutrient content, texture, population, cultural appropriateness, disease and specialized needs of the patients among other criteria, by the hospital dietitian who is knowledgeable about the patients in that hospital. RD 2 stated in the interview on August 3, 2018 starting at 9: 30 am that she updated two of the weeks of the menus. She stated she had believed that her name printed on the menu implied that she had approved the menu. RD 1 who was present during the interview and RD 2 were unable to explain and demonstrate how they approved menus if the name on the menu was that of another RD (RD 3) who according to RD 2 no longer worked for the hospital. During kitchen observations on July 31 and August 1, 2018, food service workers were observed preparing different entrée items without recipes. RD 2 in the same interview stated that she had provided recipes for menu for the weeks she had written. She acknowledged neither she nor RD 1 ensured that the food service staff had recipes to prepare all items on the five week cycle menu. RD 2 stated the menu had not been analyzed to evaluate the adequacy of nutrients and validate that it would meet the nutritional needs of the patient population because the hospital did not have the computer program that analyzes nutrients. (Cross refer A828)	A 621	New menu provided by Nutricopia Menu System are in place. RD consultants will address the new menu, training, and implementation. Nutricopia menu will provide daily production menus, standardized recipes, weekly purchasing guides, nutritional analysis, therapeutic diets, menu approval form for RD, system updates to maintain current regulatory and accepted standards of practice. Contract signed on 10/1/2018.	10/1/2018
			New menus include the recipes required. Production start date 01/01/2019.	01/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 621	Continued From page 52 Diets Clinical review of Patient 39 showed Patient 39 was admitted to the hospital with medical diagnoses of diabetes in addition to psychiatric diagnoses. Diabetes a medical condition in which the body does not produce enough insulin resulting in high blood sugar. The physician ordered diet was 2000 Cal (calorie) ADA diet-diabetic diet. The ADA (American Diabetic Association) diet is an outdated diet. In a position statement in 2002, the ADA "recommended that the term "ADA diet" no longer be used, since the ADA no longer endorses any single meal plan or specified percentages of macronutrients as it has done in the past". A review of the 2018 menu showed that there was 1800 Cal ADA and 2000 Cal ADA diets on the menu. RD 2 in the same interview of August 3, 2018 starting at 9:12 AM stated that the diets were served because that was what "was ordered by the physician". RD 1 and RD 2 acknowledged neither provided training to the medical staff. RD 2 stated that the physicians were not educated on the fact that the ADA diet was outdated. A review of the facility diet manual showed that the diet listed for the treatment of diabetes was the consistent carbohydrate diet. In an interview with the Medical Director (MD) on August 3, 2018 at 11:35 AM, the MD indicated that he had not been aware that the ADA diet was outdated and that he would not have continued to order such diets had he been educated about it. Nutrition Assessments The quality of the information nutrition gathered and used to develop nutrition assessments and medical nutrition therapy was not adequate to the scope and complexity of the population served.	A 621	New EMR will facilitate , and the availability of information to all involved will improve assessments and plan of care. New menus include the recipes required. Production start date 01/01/2019. Incorporate current standards of practice in RD assessment. RD will evaluate pt tolerance to therapeutic diets when appropriate.	01/01/2019 08/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 621	Continued From page 53 Assessments by the RDs included type of diet, height, weight, estimated caloric needs per day and a plan which was mostly checked off as "provided basic nutritional services". In an interview with RD 1 on August 1, 2018 starting at 9:10 am, RD 1 stated that all patients are assessed within 72 hours of admission. RD 1 provided a document titled "MyPyramid Food Intake Pattern Calorie Levels" which RD 1 indicated was used in estimating nutrition needs of patients. The chart which assigns calorie level based on sex, age and activity level does not take into consideration height, weight, overweight or underweight determination, protein and fluid needs. According to the 2008 ADA (American Dietetic Association) Core Registered Dietitian Standards of Practice indicators, the RD in Behavioral health "completes a more detailed analysis of the indicators to evaluate the complexity of problems and correlate one problem to another (i.e. using advanced clinical judgement skills reflecting the holistic focus of behavior health care as a complex disorder). According to Academy of Nutrition and Dietetics (formerly American Dietetic Association) RDs in behavioral Health are urged to be familiar with the Standard of Practice and Standard of Professional Performance in Behavioral Health Care. A review of five clinical records showed that this chart was used to determine the caloric needs of all the patients. The current standard of practice is to evaluate caloric, protein and fluid needs. The Academy of Nutrition and Dietetics (2017) states "the Mifflin-St Jeor equation is the most accurate (equation to use for estimating nutrient needs) for	A 621	Full time Food Service Director to implement QAPI for chart review EMR will address deficiency stated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 621	Continued From page 54 normal and obese individuals", 0.8 gm per kilogram body weight is the calculation for protein needs and 30 milliliters (a measure of volume) x kilogram body weight is the calculation for fluid needs. In the interview with RD 2 and RD 1 on August 3, 2018 starting at 9:12 AM, RD 2 stated that she was aware of nutrition assessments done with calculations of calories, protein and fluid and does so in her consultant practice in another level of care but that they have never done so at this hospital. Neither RD 1 who was present during the interview and RD 2 provided any rationale as to why they never implemented the current practice for nutrition assessment calculations and formula at the hospital. A review of the nursing initial assessment form had an incomplete information on screening patients for nutritional risk. There were a set of questions with assigned points. The form is titled "RNs Mental Health Nursing History and Assessment -AIP" dated 11/2015. However, there was no instruction on what those points indicated or what the nurses needed to do if any of the boxes was checked. In an interview with the two licensed nurses (LN N1 and CN N1) on the adult inpatient unit on August 2, 2018 at 11:30 AM, both indicated they did not understand the section on the form and did not routinely complete the section. The Chief Nursing Officer (CNO) in an interview on August 2, 2018 at 1:37 PM stated there were no policies that explained the Nutritional Screening scoring process. RD 1 stated in the August 3, 2018 interview that the form was revised about a year or so ago but the instructions were omitted in the latest	A 621	RDs will attend Nurses monthly meeting to exchange information.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 621	Continued From page 55 revision. A review of the hospital document titled "RNs Mental Health Nursing History and Assessment -AIP" dated "7/2004" under the subheading "Nutritional Assessment" listed eleven different criteria with points associated with nine of them. There was an area for total points and instructions that if a score of three is identified, dietary consult is needed within 24 hours. A review of the assessment questions indicated the screening was not tailored to the mental health population served. A 2006 document titled "Assessment of Eating Behaviors for patients with Acute Mental Illness" by The Dietetics in Developmental and Psychiatric Disorders Practice Group of the American Dietetic Association, lists screening and assessment questions appropriate for this group. The lists included assessment of cognitive behaviors such as decreased awareness of need to eat, paranoid about food, Eating Behaviors such as bites too large for safe swallow, social behavior such as demanding behavior in the dining room as part of the assessment for the population served. These are some of the same behaviors documented in the patients in the hospital. Collaboration with other services 1. Patient 40 was admitted with diagnoses including schizophrenia. Patient 40 believed his food was being poisoned and so he refused to eat. The physician's order for Patient 40 was a regular diet and nutritional supplements three times a day. Nursing staff did not observe Patient 40 consuming meals from 7/12/18, date of admission through 7/26/18 when he was transferred to the acute care hospital. Patient 40 refused all nutritional supplements from 7/12/18	A 621	1. RDs will attend Nurses monthly meetings to exchange information.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 621	Continued From page 56	A 621		

through 8/2/18. Patient 40 weighed 138 lbs. on admission, lost 11 pounds in 14 days before he was transferred to an acute care hospital for rehydration.

Clinical record review of Patient 40 indicated the RD completed a nutrition assessment on the day of admission. The RD did not complete any other assessments or documentation when Patient 40 continued to refuse meals and lost 11 pounds. Nursing notes indicated that nurses attempted to provide meals in sealed containers to reassure Patient 40 that meals were not tampered with. In an interview with LN N1 on August 2, 2018 at 12:30 PM, LN N1 indicated Patient 40 was offered "cup of noodle". The noodle dish is prepared by adding water to dehydrated noodle. The container had to be opened to prepare the item and may have contributed to why Patient 40 did not consume it. Other prepackaged products such as packaged frozen dinners, could have been offered to Patient 40 that would have not been opened to prepare and serve. The Foodservice manager (FSM) on August 2, 208 at 4: 25 PM stated that they have prepackaged products that they occasionally obtain for patients such as those on Kosher diets that would have been appropriate for Patient 40 had the RD requested it.

LN N1 acknowledged in the interview on August 2, 2018 at 12:40 PM the nursing staff did not refer Patient 40 to the RDs. LN N1 stated in the same interview that it was not part of the hospital protocol to call the RD if a patient does not eat, they (nursing staff) call the physician. RD 2 in the interview on August 3, 2018 starting at 9:12 am stated that she was not aware of Patient 40's weight loss and his meal refusals. RD 2 indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
A 621	Continued From page 57 she attempted to reassess Patient 40 when she received a "stat" order from the physician for a nutrition consult on 7/26/18 but on 7/27/18 when she visited Patient 40, he was eating. 2. During meal observation on July 31, 2018 at 12:16 PM, four of the eight patients present in the children's unit did not consume all their meals. CNA N1 who was present stated some of the patients may not have been hungry because they may have just had snacks. CNA N1 indicated one the patients just had BBQ chips less than one hour before lunch and another was just given two cupcakes, of which he had consumed one, for cleaning his room. CNA N1 stated on July 31, 2018 at 12:30 PM, the patients are given snacks and also receive food as incentives and rewards. According to the University of Rochester Medical Center "using food as a reward or as a punishment, however, can undermine the healthy eating habits that you are trying to teach your children. Giving sweets, chips, or soda as a reward often leads to children overeating foods that are high in sugar, fat, and empty calories. Worse, it interferes with kids' natural ability to regulate their eating. It also encourages them to eat when they are not hungry to reward themselves". ActionforHealthyKids.org states that the goal of rewarding ...is to help internalize desirable behaviors and create motivation ... that comes from inside and that effective rewards should promote healthy living ..." Both RDs indicated on August 1 and 3, 2018 at 9:15 am they were not aware that food was being used as an incentive in the children's unit. 3. During the discussion about participation in the Pharmacy and Therapeutic (P&T) Committee, RD	A 621	2. RD to train staff on meal timing and appropriate meal service behavior on November 20, 2018.	11/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 621	Continued From page 58 1 and RD 2 indicated on August 3, 2018 at 9:48 AM, that they do not participate in the meetings because they are held on days or times they are not scheduled to be in the hospital. RD 1 stated on August 3, 2018 at 9:50 AM, the RDs also do not attend "due to other obligations". Physician education, nutrition therapy including use of food as an incentive and updating of diet manuals would be appropriate topics that the RDs could have been brought forward to the P&T committee. 4. On August 2, 2018 at 4:30 PM, Food Service Manager (FSM) made changes to the pediatric menu because it was "not enough food for the children". FSM in a concurrent interview and observation stated in response to getting RD approval for diet/menu changes, she does not know how to reach the RD and would have to get the hospital operator to reach them. The hospital did not have a system in place to ensure communication existed between the RDs and food service staff. Oversight During the tour of the kitchen, there were many deficient practices identified resulting in immediate jeopardy. In the interviews with RD1 on August 1, 2018 and RD 1 and 2 on August 3, 2018, RD 1 and RD2 stated they had limited oversight of the kitchen and do in services and monthly kitchen sanitation checks. RD 1 stated in the August 3, 2018 interview that the RDs do not have any authority to speak with the food and nutrition staff. Diet Manual A review of the diet manual indicated that the last it was approved was in 2014. The community	A 621	Food Service Director , RD will develop policies regarding food substitution A training was provided to food service staff on following the protocol regarding food substitution. Diet Manual will be updated and approved on an annual basis and training will be provided to staff on the diet and Diet Manual.	10/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 621	Continued From page 59 standards for approval of menu is yearly. QAPI In the interview on August 3, 2018 starting at 9:12 AM, both RD 1 and RD2 indicated they currently do not have any performance improvement projects going on and did not develop any in the past. RD 1 stated her monthly audits are presented to the administrator and director of food services. A review of the facility document titled "Sanitation Report" completed monthly by RD 1 from November 2017 through April 2018 showed poor labeling as one of the identified concerns. Most of the other deficient practices identified during the survey were however, not identified by RD 1.	A 621	On line compliance audit available for RDs was updated. New full time RD will conduct QAPI. RDs are now part of the Executive Medical Committee.	
A 629	THERAPEUTIC DIETS CFR(s): 482.28(b), (b)(1) §482.28(b) Menus must meet the needs of patients. (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: Based on review of menu, review of clinical records and staff interviews, the hospital failed to ensure that the menu was analyzed to determine that it met the needs of all of its patients. The five-week menu currently used by the hospital was developed by different dietitians and some of which do not have recipes to determine its ingredients, preparation methods and therefore its nutrient content. This had the potential to affect the nutrition status of all 50 patients admitted during the survey. In addition, the	A 629	Standardized recipes are in place and portion control in-service will be provided. On-going QAPI has been implemented with test trays. (Attachment S)	09/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 629	Continued From page 60 hospital failed to ensure the nutritional needs of two sampled patients (Patients 39 and Patient 40) were met in accordance with recognized dietary practices. These failures resulted in weight loss of 11 pounds in 14 days for Patient 40 and potential to choke in Patient 39. (Cross refer A 621) Findings: A review of week 4 of the five-week hospital menu did not indicate the registered dietitian (RD) approved the menu. The approval of the menu signifies that it has been reviewed and deemed appropriate in terms of the nutrient content, texture, population, cultural appropriateness, disease and specialized needs of the patients among other criteria, by the hospital dietitian who is knowledgeable about the patients in that hospital. During kitchen observations on July 31 and August 1, 2018, food service workers were observed preparing different entrée items without recipes. On July 31, 2018 at 1:45 PM, Food service worker (FSW 1) prepared a fruit salad with cantaloupe, honeydew melon, pineapple and grapes and poured over the fruit unmeasured quantity of drinkable yogurt. In a concurrent interview and observation, FSW 1 stated there was no recipe for the fruit salad. On August 1, 2018 at 3:00 PM, Cook 1 was interviewed on the preparation methods used to prepare the Cheese enchilada that had been prepared for dinner. Cook 1 said he did not have a recipe but followed the directions on the box of the Enchiladas. According to the menu, patients on regular diet were to be served 3 ounces of	A 629	Standardized recipes are in place and portion control in-service will be provided. On-going QAPI has been implemented with test trays. (Attachment S). An in-service was conducted by the RD food service consultant on Menu Production on September 28, 2018 (Attachment T).	09/25/2018 09/28/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 629	Continued From page 61 Cheese enchilada bake casserole. It was not clear if the other ingredients were required to make the cheese enchilada bake. The serving size on the box of the Cheese enchilada was two. The two enchiladas will provide 17 grams of protein. If the 3 ounces written as portion implied the protein content of the enchilada was 3 ounces, the amount of the enchilada given was less than 3 ounces. Three ounces is 21 grams of protein, the two enchiladas were 17 grams (or 2 -1/2 ounces) protein, four grams less than was planned on the menu. There were seven patients on a Double Portions (DP) diet. There were no written menu or instructions on how much food to serve patients on this diet. During meal service observation on August 1, 2018 at 10:47 AM, patients on double portions diet were served a chicken breast and one wing of BBQ chicken. Cook 2 in a concurrent observation and interview stated the patients on double portion diets were to receive double the protein on all meals but was unclear whether there were increases for other items on the meal such as bread, vegetables. Cook 2 dished out double the vegetable (broccoli) after the surveyor asked questions. The breast and wing served was not twice the protein. In an interview with RD 1 on August 1, 2018 starting at 9:12 am, RD 1 stated she was unsure of the serving of double portion, believes it was double meat but unsure of the exact amount. RD 2 provided a document titled "Menu pattern Regular diet and Double Portions Diet" dated 3/1/12. According to the document, patients on double portions diet receive double the serving of bread at breakfast: two boxes of cold cereal versus one for patients on regular diet, four slices	A 629	Training for the new menu and recipes are on-going with kitchen staff.	

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A 629	Continued From page 62 of bread vs two slices during breakfast. For lunch, patients on double portions receive 5 ounces of protein versus 3 ounces for patients on regular diets. The DP diet receive double starch, vegetables and whole wheat bread. For dinner, the pattern is the same as lunch. A review of week 4 of the five- week menu showed limited variety in the starches and vegetables offered. There were repetition of food items from one meal to another or day- to-day. For example on 7/31/18, Tuesday, broccoli with cheese sauce was served for lunch. For dinner, patients were served bean broccoli salad. On Wednesday 8/1/18, peas/glazed carrots was the vegetable for lunch and glazed carrots was the vegetable for dinner. Patients received garlic mashed potato on Monday for dinner, Wednesday for lunch, oven browned potatoes for lunch on Thursday and mashed potatoes for dinner also on Thursday. For Thursday lunch, roasted red potatoes. Meal repetition limits the kind of nutrients a patient will receive and may affect intake due to reduced satisfaction. RD 2 stated the menu had not been analyzed to evaluate the adequacy of nutrients and validate that it would meet the nutritional needs of the patient population because the hospital did not have the computer program that analyzes menus for their nutrients. (Cross refer A629) Diets Clinical review of Patient 39 showed Patient 39 was admitted to the hospital with medical diagnoses of diabetes in addition to psychiatric diagnoses. Diabetes a medical condition in which the body does not produce enough insulin resulting in high blood sugar. The physician	A 629	A new menu is now in place. Training food service staff on using the menu and recipes are carried out by the consulting food service RD.	

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A 629	Continued From page 63 ordered diet was 2000 Cal (calorie) ADA diet-diabetic diet. The ADA (American Diabetic Association) diet is an outdated diet. In a position statement in 2002, the ADA "recommended that the term "ADA diet" no longer be used, since the ADA no longer endorses any single meal plan or specified percentages of macronutrients as it has done in the past". A review of the 2018 menu showed that the RDs had an 1800 Cal ADA and 2000 Cal ADA diets as part of the diets offered. RD 2 in the same interview of August 3, 2018 starting at 9:12 AM stated that the diets were served because that was what was ordered by the physician. RD 2 stated that the physicians were not educated on the fact that the ADA diet was outdated. A review of the facility diet manual showed that the diet listed was the consistent carbohydrate diet. In an interview with the medical director (MD) on August 3, 2018 at 11:35 AM, MD stated that the RDs did not inform him about the needs of the department. MD stated was not aware the ADA diet was outdated. Nutrition Assessments In an interview with RD 1 on August 1, 2018 starting at 9:10 AM, RD 1 stated that all patients are assessed within 72 hours of admission. RD 1 provided a document titled "MyPyramid Food Intake Pattern Calorie Levels" which RD 1 indicated used in estimating nutrition needs of patients. The chart which assigns calorie level based on sex, age and activity level does not take into consideration height, weight, overweight or underweight determination, protein and fluid needs. According to the 2006 ADA (American Dietetic	A 629	New EMR will facilitate , and the availability of information to all involved will improve assessments and plan of care. New menus include the recipes required. Production start date 01/01/2019. Diet orders were updated in the new EMR. New Menu will provide nutrition analysis , and serving size. In-service on Menu Production is currently being provided to food service staff.	01/01/2019 11/30/2018

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A 629	Continued From page 64 Association) Core Registered Dietitian Standards of Practice Indicators, stated the RD in Behavioral health "completes a more detailed analysis of the Indicators to evaluate the complexity of problems and correlate one problem to another (i.e. using advanced clinical judgement skills reflecting the holistic focus of behavior health care as a complex disorder) A review of five clinical records showed that this chart was used to determine the caloric needs of all the patients. There were no complex analysis of the nutritional needs of each of the patients reviewed. The current standard of practice is to evaluate caloric, protein and fluid needs. The Academy of Nutrition and Dietetics (2017) states "the Mifflin-St Jeor equation is the most accurate (equation to use for estimating nutrient needs) for normal and obese individuals". 0.8 gm per kilogram body weight is the calculation for protein needs and 30 milliliters (a measure of volume) x kilogram body weight is the calculation for fluid needs. In the interview with RD 2 and RD 1 on August 3, 2018 starting at 9:12 AM, RD 2 stated that she was aware of nutrition assessments done with calculations of calories, protein and fluid and does so in her consultant practice in another level of care but that they have never done so at this hospital. Neither RD 1 who was present during the interview and RD 2 provided any rationale as to why they never implemented the current practice for nutrition assessment calculations and formula at the hospital. Menu There was no difference in the amount served to children and adults. Tuesday and Wed, same for all three meals. The amounts for other days were identical with the exception of few entrees. The	A 629	The new EMR - Avatar developed to offer complex analysis of the nutritional needs of each patient, identify therapeutic needs and a plan of care.	01/01/2019

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A 629	Continued From page 65 age group of the children during the survey was 6 - 12 years old. According to the hospital document provided by the RDs titled MyPyramid Food Intake Pattern Calorie Levels" by the USDA the caloric need for the children in this age group is between 1200 to 1800 calories for sedentary activity. Serving the same food to children and adults whose caloric need is 2000 to 2600 calories is not appropriate. Excessive amounts of food could result in overeating resulting in inappropriate weight gain. Nutritional Needs 1. Patient 40 was admitted with diagnoses including schizophrenia. Patient 40 believed his food was being poisoned and so he refused to eat. The physician's order for Patient 40 was a regular diet and nutritional supplements three times a day. Nursing staff did not observe Patient 40 consuming meals from 7/12/18, date of admission through 7/26/18 when he was transferred to the acute care hospital. Patient 40 refused all nutritional supplements from 7/12/18 through 8/2/18. Patient 40 weighed 138 lbs. on admission, lost 11 pounds in 14 days, before was transferred to an acute care hospital for rehydration. A 7.9 % weight loss in two weeks, is a severe weight loss. According to current standard of practice weight loss of greater than 5% in one month is severe. Clinical record review of Patient 40 indicated the RD completed a nutrition assessment on the day of admission. The RD did not complete any other assessments or documentation when Patient 40 continued to refuse meals and lost 11 pounds. Nursing notes indicated that nurses attempted to provide meals in sealed containers to reassure Patient 40 that meals were not tampered with. In	A 629	1. RDs provide re-assessments per local policy. Nursing provides RD consults at briefs for poor appetite, refusal of meals and poor intake. (Attachment V)	

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A 629	Continued From page 66 an interview with LN N10 on August 2, 2018 at 12:30 PM, LN N10 indicated Patient 40 was offered "cup of noodle". Cup of noodle is prepared by adding water to dehydrated noodle. The container had to be opened to prepare the item and may have contributed to why Patient 40 did not consume it. Other prepackaged products such as some packaged dinners, could have been offered to Patient 40 that would have not been opened to prepare and serve. The Food service manager (FSM) on August 2, 208 at 4: 25 PM stated that they have prepackaged products that they occasionally obtain for patients such as those on Kosher diets that would have been appropriate for patient 40 had the RD requested it. LN N10 acknowledged the nursing staff did not refer Patient 40 to the RDs. LN N10 stated in the same interview that it was not part of the hospital protocol to call the RD if a patient does not eat, they call the physician. RD 2 in the interview on August 3, 2018 starting at 9:12 AM stated that she was not aware of Patient 40's weight loss and his meal refusals. RD 2 indicated she attempted to reassess Patient 40 when she received a "stat" order from the physician for a nutrition consult on 7/26/18 but on 7/27/18 when she visited Patient 40, he was eating. There was no documentation of the consult. 2. During meal observation on August 1, 2018 at 12:10 PM, in the adult in-patient unit, Patient 39 was served the following: BBQ Chicken, broccoli, mashed potato in a container. She received an additional container with yogurt, jello which was described as soft diet. Patient 39 had difficulty biting into the BBQ chicken. Patient 39 moved the large chicken breast along every area of her	A 629	RD will continue to train nurses on how to handle pt nutritional requests. In addition, RDs will attend monthly Nursing Meetings.	

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A 629	Continued From page 67 mouth trying to cut into the chicken and could not bite into it. About a minute or so later she pulled it out of her mouth and tore off pieces of chicken with her hands and shoving large pieces of the meat in her mouth. It looked like she was going to choke. The nursing staff in the room did not redirect her to slow down or offer to cut the food. Observation showed Patient 39 was edentulous (no teeth). Review of clinical record showed Patient 39 was admitted to the facility about seven and a half months before and had been placed on a 2000 calorie ADA diet. She had been assessed by the RD on 12/15/17. The RD marked that she did not have difficulty chewing or swallowing. There was no other documented evidence that the RD reassessed her. A review of her master treatment Plan - Interdisciplinary Plan of care did not identify her lack of teeth as a problem. On 2/23/18, the care plan under the heading Dietitian, stated "No dietary issues at this time". There was no documentation in her clinical record that she had no teeth or use of dentures. In an interview with CNA N2 on August 2, 2018 at 11:30 AM, CNA N2 stated Patient 39 does not have teeth "but she eats". Patient 39 was not properly assessed to ensure that the diet and texture were appropriate to prevent choking. RD 2 in an interview on August 3, 2018 at 9:48 AM, stated Patient 39 would not eat ground meat and would want regular meats from the menu. There was no documented evidence that the Patient 39 would not eat the food of the appropriate texture to prevent accidental choking. Patient 39 was not reassessed after the initial assessment. Professional standards of practice	A 629	A nursing staff is always available in the dinning room with patients. Pt 39 refused to eat mechanically soft food , and requested regular foods. Pt 39 has been in the facility since Dec 12, 2017 ,has been eating regular foods with no chocking issues. RDs provide re-assessments per local policy. Nursing provides RD consults for chewing/swallowing difficulties. Care Plans implemented in the new EMR to address problems identified in RD assessments. (Attachment V	

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A 629	Continued From page 68 require reassessment of patients in a hospital. There was no policy in place that guided the practice of when reassessment will be conducted. 3. During meal observation on July 31, 2018 at 12:15 PM, four of the eight patients present in the children's unit did not consume all their meals. CNA N1 who was present during the observation stated some of the patients may not have been hungry because they may have just had snacks. CNA N1 indicated one the patients just had BBQ chips less than one hour before lunch and another was just given two cupcakes, of which he had consumed one, for cleaning his room. CNA N1 stated on July 31, 2018 at 12:30 PM, the patients are given snacks and also receive food as incentives and rewards. According to the University of Rochester Medical Center "using food as a reward or as a punishment, however, can undermine the healthy eating habits that you are trying to teach your children. Giving sweets, chips, or soda as a reward often leads to children overeating foods that are high in sugar, fat, and empty calories. Worse, it interferes with kids' natural ability to regulate their eating. It also encourages them to eat when they are not hungry to reward themselves". ActionforHealthyKids.org states that the goal of rewarding ...is to help internalize desirable behaviors and create motivation ... that comes from inside and that effective rewards should promote healthy living ..." Both RDs indicated on August 3, 2018 at 9:15 AM they were not aware that food was being used as an incentive or reward in the children's unit. 4. During the discussion about participation in the Pharmacy and Therapeutic (P&T) Committee, RD	A 629	New EMR addressing the follow up assessment and meeting professional standards. RD will train and educate staff on timing of meals and appropriate /meal serving behavior.	01/01/2019 12/01/2018

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A 629	Continued From page 69 1 and RD 2 indicated on August 3, 2018 at 9:48 AM, that they do not participate in the meetings because they are held on days or times they are not scheduled to be in the hospital. RD 1 stated on August 3, 2018 at 9:50 AM, the RDs also do not attend "due to other obligations". Physician education, nutrition therapy including use of food as an incentive and updating of diet manuals would be appropriate topics that the RDs could have been brought forward to the P&T committee. 5. On August 2, 2018 at 4:30 PM, Food Service Manager (FSM) made changes to the pediatric menu because it was "not enough food for the children". FSM in a concurrent interview and observation stated in response to getting RD approval for diet/menu changes, she does not know how to reach the RD and would have to get the hospital operator to reach them. The hospital did not have a system in place to ensure communication existed between the RDs and food service staff. 6. During meal observation in the Children's In Patient (CIP) unit on July 31, 2018 at 12: 20 PM, Patient 24 asked for water while eating. There were no water cups, pitchers or other visible source of water in the room where the meals was being consumed. The CNA N1 who was present during the meal told the patient there was juice on the table. The patient was not provided water during that meal. During meal observation on August 1, 2018 at 12:10 PM the Adult in patient unit, Patient 38 had asked for ice. The Mental Health Technician (MHT) who supervised the patients stated there was no ice available. Patient 38 continued to ask	A 629	Restructuring the Dietary Dept to include qualified staff provide training, education and should meet and ensure that the pt nutritional needs are met according to standard. This includes being an RD representative in the P&T meetings.	

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 629	Continued From page 70 for ice singing "Ice, ice, baby" with the request for ice getting louder. MHT scooped ice from the container that held the frozen dessert and provided to Patient 38. This ice could have been a potential source of contamination. In an interview with the MHT on August 1, 2018 at 12:30 PM, MHT stated the patients only have access to water. In an interview with the Food service Manager (FSM) on August 2, 2018 at 4:05 PM, FSM stated there is no water on the menu and so it is not provided. FSW also stated they do not serve ice. In an interview with the RD 1 and RD 2 on August 3, 2018 starting at 9:12 AM, RD 1 stated the kitchen does not provide water to the patient units. She indicated there was a water foundation in the hallway where the children could access water. She did not respond when the surveyor asked if the expectation was that the children leave the table to drink water from the fountain. Regarding the adult unit, RD 2 stated she was unclear why water was not provided and that possibilities include water being thrown at other patients.	A 629	1) In-service staff on infection control 2) Request a container of ice for the patients use only during meals. 3) Staff will be given pre/post test on food safety and bacterial growth. 4) Monthly audit and tracking refrigerator content will be implemented. 5) Observe Meal Pass weekly for one month and then monthly thereafter. Responsible individual: Nursing Supervisor and/or DON. A secure water container is always available to pt during meal time. Water fountain is available all the time.	11/20/2018
A 630	DIETS CFR(s): 482.28(b)(2) All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals. This STANDARD is not met as evidenced by: Based on review of clinical record and staff	A 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 630	Continued From page 71 Interviews, the facility failed to ensure that diet orders were ordered by the practitioner responsible for the care of the patient. Two sampled patients (Patients 37 and 38) did not have diet orders prescribed by their physicians. Findings: Clinical record review for Patient 38 indicated the patient was admitted on 7/31/18 with diagnoses including bipolar disorder. The physician did not order a diet for the patient. The patient was served a Regular diet. According to the Diet requisition list for August 1, 2018. During meal observation, Patient 38 received a regular diet. Patient 37 was admitted on 8/1/18. A review of the Physician Admission orders showed no diet was ordered for the patient. The lack of a diet order was not identified by the RD who had completed a Nutrition/Dietary assessment on 8/3/18. The Patient was served a regular diet. In an interview with LN N9 on August 3, 2018 at 12:30 PM, LN N2 stated the RN who carried out the order was not available for interview but must have forgotten to verify the diet orders but that the physician wrote the order himself.	A 630	EMR charting will ensure the that patients will have diet order requested by the MD or the registered RD. A QAPI for Diet Orders will be implemented on December 10, 2018.	12/10/2018
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by:	A 700		

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A 700	Continued From page 72 Based on observation, interview and document review it was determined that the facility did not meet the Condition of Participation (COP) for Physical Environment by failing to: 1. Maintain In Patient accessible areas free of fixtures that were not of anti-ligature design or anti-ligature protected, that could be used as anchor points to tie to and that can hold a person's weight. (Refer to A 701) 2. Maintain a bathroom sink fixture as to not have and exposed water valve stem. (Refer to A 701) 3. Maintain a patient room corridor door secured firmly to its door frame assembly. (Refer to A 701) 4. Maintain patient room wall finishes to be easily cleaned and disinfected. (Refer to A 701) 5. Maintain a food storage room free of accumulation of dust. (Refer to A 701) 6. Maintain a food storage and preparation area free of chemicals and material that could adulterate food. (Refer to A 701) 7. Maintain a dishwashing area wall clean and free of accumulation of black material growth. (Refer to A 701) 8. Maintain ceiling tiles free of water damage. (Refer to A 701) 9. Maintain posted warning signage of water that is 120 oF (degrees Fahrenheit) or higher. (Refer to A 701) 10. Provide documented evidence of an	A 700		

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A 700	Continued From page 73 assessment conducted to determine the quantity of emergency water needed by the facility. (Refer to A 703) 11. Maintain a sight glass of the fuel gauge at the emergency generator's day tank so that the fuel level in the tank could be read. (Refer to A 709) 12. Maintain the main electrical panel room free of storage. (Refer to A 709) 13. Maintain the main electrical panel room and boiler room walls free of penetrations. (Refer to A 709) 14. Maintain the storage room corridor door free of penetration. (Refer to A 709) 15. Maintain the Information Technology (IT) server room ceiling free of penetrations. (Refer to A 709) 16. Maintain smoke and fire barriers free of penetrations. (Refer to A 709) 17. Maintain patient room walls of combustible or limited combustible construction. (Refer to A 709) 18. Maintain exit doors unobstructed. (Refer to A 709) 19. Ensure corridor doors can hold closed when shut. (Refer to A 709) 20. Maintain a corridor door in place. (Refer to A 709) 21. Maintain an astragal at corridor Dutch door. (Refer to A 709)	A 700		

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	054083	A. BUILDING _____ B. WING _____	09/03/2018

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A 700	Continued From page 74	A 700		

22. Maintain exit signage and exit directional signage available and unobstructed from view, from any part of the occupied area. (Refer to A 709)

23. Maintain fire extinguisher and hose in corridor cabinet readily accessible by maintaining a handle at the cabinet door. (Refer to A 709)

24. Maintain fire extinguisher properly hung as to not damage hose. (Refer to A 709)

25. Maintain an 18 inch clearance between the bottom of a sprinkler head deflector and the top of storage. (Refer to A 709)

26. Maintain electrical cover plate free of damage. (Refer to A 709)

27. Maintain Kitchen suppression system blow off caps in place. (Refer to A 709)

28. Maintain an oxygen cylinders secured, separate empty from full and identified by posted signage. (Refer to A 709)

29. Correctly use extension cords including power strips. (Refer to A 709)

30. Maintain documented evidence of inspection and testing of drop down fire doors, and rating plates legible. (Refer to A 709)

31. Maintain documented evidence of sensitivity of the smoke detectors. (Refer to A 709)

32. Maintain documented evidence that the transfer switch was being inspected and tested.

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A 700	Continued From page 75 (Refer to A 709)	A 700		

33. Maintain documented that transfer time of emergency power was being tested. (Refer to A 709)

34. Maintain documented evidence that smoking regulations were adopted for smoking by patients. (Refer to A 709)

35. Ensure facilities and food service equipment were maintained to an acceptable level of safety for patients and staff; ensure the water faucet was working in the handwashing sink located inside the medication storage area at the children inpatient nursing unit (CIP). (Refer to A 724)

36. Maintain eyewashes in a condition to provide quick drenching or flushing of the eyes with water delivered at a tepid temperature. (Refer to A 724)

37. Maintain documented evidence of testing of the eyewash stations. (Refer to A 724)

38. Maintain light fixtures diffusers/covers and light shields in good repair and in place. (Refer to A 724)

39. Maintain ceiling light fixtures to provide light at kitchen working areas. (Refer to A 726)

40. Maintain light in food storage refrigerator freezer. (Refer to A 726)

41. Monitor temperatures in all pharmaceutical storage areas with instrumentation that has the range to determine if the ambient room temperature is out of range. (Refer to A 726)

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A 700	Continued From page 76 The cumulative effect of these systemic problems resulted in the Facility's inability to ensure the provision of quality health care in a safe and sanitary environment.	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to develop and maintain the physical plant in a manner that assured the safety and well-being of patients. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients. Findings: Basement 1) On 7/31/18 at 10:46 a.m., the evaluator observed that in the dietary storage room there was an accumulation of dust at a ceiling air return register. On 8/1/18 between 8:30 am and 2:30 pm the following conditions existed at the facility. 1st Floor Kitchen	A 701	A 701 Plan of Correction # 1 The air return and supply registers in the dietary storage room were cleaned by the Kitchen staff on this findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department ATTACHMENT # 1	08/03/2018

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A 701	Continued From page 77 2) The evaluator observed the temperature of the water at the hand wash sink was tested with a result of 120 oF (degrees Fahrenheit). Further observation revealed there was no posted sign warning about the 120 of water temperature. During an interview at the same time as the observation, the Director of Facilities acknowledged the water temperature was 120 oF, that there was no posted signage that the water was 120 oF.	A 701	A 701 Plan of Correction # 2 The motion activated faucet in the hand washing sink was removed and replaced with a hand activated faucet and the water temperature was adjusted accordingly on 08/03/2018. ATTACHMENT # 2	08/03/2018
	3) The evaluator observed there was a squeeze application bottle containing machine oil laying on an electrical conduit next to a reach in refrigerator use for spice storage at cooking area of the kitchen. During an interview at the same time as the observation a kitchen staff stated that oil was used to loosen screw on the cooking equipment.		A 701 Plan of Correction # 3 The lubing oil squeeze application bottle was permanently removed by the food serviced Director and properly discarded of on 08/01/2018. NO ATTACHMENT	08/01/2018
	4) The evaluator observed there was a 2 vertical foot accumulation of black material at the corner of a tiled wall in the dishwashing area. During an interview at the same time as the observation the Director of Facilities stated the kitchen is cleaned daily, but that spot must have been missed.		A 701 Plan of Correction # 4 The tile area around the dish washing area was cleaned by the Housekeeping cleaning crew on 08/03/2018 ATTACHMENT # 3	08/03/2018
	2nd Floor Administration 5) The evaluator observed there was sign of water damage including brown staining at the ceiling of the conference room.		A 701 Plan of Correction # 5 The water damage in the board room was repaired by the engineering department on 10/15 2018 ATTACHMENT # 4	10/15/2018

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A 701	Continued From page 78 2nd floor Children In Patient (CIP 2) 6) The evaluator observed two of three men's patient common bathrooms had standard faucets that could be used as anchor points to tie to that can hold a person's weight. During an interview at the same time as the observation the Director of Facilities stated that the patients go into the bathrooms unaccompanied. The Director of Facilities also stated that they ordered anti-ligature faucets, but that the standard faucets had not been replaced with the anti-ligature faucets because they ran out. 7) The evaluator observed the doctor's office had seven water damaged ceiling tiles. 8) The evaluator observed the dining room had a wall clock that was set 4 hours behind. 9) The evaluator observed that in room 212 there was peeling and missing paint at a wall, exposing unfinished porous plywood surfaces. Housekeeping provided labels of products used to clean and disinfect the patient room walls. The products' labels, including the product used for terminal cleaning, indicated that the product was to be used on non-porous surfaces. 3rd floor Adult In Patient (AIP 1) 10) The evaluator observed there were fixtures that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed sink drain line and standard	A 701	A 701 Plan of Correction # 6 All of the bathroom faucets in the Adult In Patient (AIP-2 & AIP-2) and Children In Patient Unit (CIP) have been purchased and will be replaced with ligature proof faucets by the engineering department by 11/30/2018 ATTACHMENT # 5 A 701 Plan of Correction # 7 All of the ceiling tiles in the Dr's office was replaced the engineering department on 08/06/2018 ATTACHMENT # 6 A 701 Plan of Correction # 8 The dining room clock battery was replaced on 08/03/2018 and time was set accordingly by the engineering department ATTACHMENT # 7 A 701 Plan of Corrections # 9 Room 212 was painted by the engineering department on 08/06/2018 all of the existing plywood on the AIP and CIP units will be removed and walls will be repaired to their original condition Please refer to: K 163 Plan of Corrections ATTACHMENT # 8	11/30/2018 08/03/2018 08/06/2018

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A 701	Continued From page 79 faucets. The evaluator observed patient room 375's bathroom sink had exposed plumbing pipes that could be used as anchors. During an interview at the same time as the observation the Director of Facilities acknowledged the exposed pipes, stated that the cover for the pipes was missing and the pipes should not be exposed. The evaluator observed patient room bathrooms, including those in rooms 334, 339, 341, 348, 351, 352, 354, 357, and 362 had standard faucets that could be used as anchors. During an interview the Director of Facilities stated that he had recently replaced the faucets thinking they were anti-ligature faucets because the manufacturer's literature stated the faucets were National Sanitation Foundation (NSF) safe for use in health facilities. The Director of Facilities also stated that the faucets could be replaced with anti-ligature faucets. The evaluator's review of the manufacturer's literature provided by the Director of Facilities revealed that there was no indication in the literature that the faucets were ant-ligature. 11) The evaluator observed in room 356 the handle was missing from the hot water valve at the bathroom sink. 12) The evaluator observed at room 356 the top hinge of the corridor door was loose causing the door to drag against the floor.	A 701	A 701 Plan of Correction # 10 The Missing under sink Cove was replaced in patient room # 375 by the engineering department on 08/06/2018 All of the bathroom faucets in the AIP and CIP Units Will be replaced with ligature resistant faucets Please refer to A 701 Plan of Correction # 6 A 701 Plan of Correction # 11 Please refer to: 701 Plan of Correction # 6 A 701 Plan of Correction # 12 A new door was installed in room 356 please refer to:K 383 Plan of Correction # 2	08/06/2018

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A 701	Continued From page 80 13) The evaluator observed in rooms 341, 345 there was peeling and missing paint at a wall, exposing unfinished porous plywood surfaces. Housekeeping provided labels of products used to clean and disinfect the patient room walls. The products' labels, including the product used for terminal cleaning, indicated that the product was to be used on non-porous surfaces. 3rd floor Adult In Patient (AIP 2) 14) The evaluator observed there were fixtures that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed sink drain line and standard faucets. Patient room 313's bathroom sink had exposed plumbing pipes that could be used as anchors. During an interview at the same time as the observation the Director of Facilities acknowledged the exposed pipes, stated that the cover for the pipes was missing and the pipes should not be exposed. The evaluator observed patient room bathrooms, including those in rooms 312, 313 and 317 had standard faucets that could be used as anchors. During an interview the Director of Facilities stated that he had recently replaced the faucets thinking they were anti-ligature faucets because the manufacturer's literature stated the faucets were NSF (National Sanitation Foundation) safe for use in health facilities. The Director of Facilities also stated that the faucets could be	A 701	A 701 Plan of Correction # 13 All the Existing Plywood will be removed from the AIP and CIP units Please refer to: K 163 Plan of Correction A 701 Plan of Correction # 14 The missing under sink cover was replaced in room 313 on 08/05/2018 all of the bathroom g faucets will be replaced with ligature resistant faucets Please refer to: A 701 Plan of Correction # 6	08/05/2018

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A 701	Continued From page 81 replaced with anti-ligature faucets. Review of the manufacturer's literature provided by the Director of Facilities revealed that there was no indication in the literature that the faucets were ant-ligature. 15. On 8/3/18 at 9:25 a.m., during an observation of the Treatment Room on the CIP Unit with RN 5, it was noted that the sink faucets did not work. RN 5 stated he was not aware the faucets were not working, and would notify the Maintenance Department. On 7/31/18 at 3 p.m., during the initial tour, it was observed that the entrance door of the CIP Unit slammed shut during ingress and egress. On 8/3/18 at 8:45 a.m., it was noted that the door again slammed shut. On 8/3/18 at 2 p.m., during an interview, the Director of Materials Reprocessing stated he would have the door adjusted so that it would close quietly.	A 701	The CIP Entrance door closer was adjusted by the engineering department on 08/05/2018 NO ATTACHMENT	08/05/2018
A 703	EMERGENCY GAS AND WATER CFR(s): 482.41(a)(2) There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to provide documented evidence of a system to provide emergency water and failed to ensure an effective water management plan to be implemented in a widespread disaster by not providing documentation of the amount of emergency water needed by the facility.	A 703		

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A 703	Continued From page 82 This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: On 8/2/18 at 1:18 p.m., the evaluator's review of the facility's disaster preparedness plan revealed there was no documented evidence that an assessment had been made determine the quantity of water needed for drinking, cleaning and food preparation. At the same time as the plan review the Disaster Coordinator stated that the Dietary Director had the breakdown of the quantity of water needed. The evaluator's review of the documents provided by the Dietary Director revealed that they also did not include an assessment had been made determine the quantity of water needed.	A 703	A new Water Failure Policy Section has been added to the emergency operations plan on 08/05/2018. this policy section will be presented to the emergency management committee for review and approval on the October 24, 2018 emergency management committee meeting. committee member will be in-serviced in the new policy section during the meeting please refer to: E 015 Plan of Correction ATTACHMENT # 9	08/05/2018
A 709	LIFE SAFETY FROM FIRE CFR(s): 482.41(b) Life Safety from Fire This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that the life safety from fire requirements were met. The deficiency had the potential to not provide the minimum requirements of the Life Safety Code and referenced Codes and Standards.	A 709		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 709	Continued From page 83 Findings: On 7/31/18 between 9 am and 11 am the following conditions existed at the facility. Exterior Physical Plant 1) The evaluator observed the sight glass of the fuel gauge at the emergency generator's day tank was weathered opaque, so that the fuel level in the tank could not be read. During an interview at the same time as the observation, the Mechanical Engineer stated that he did not know how much fuel was in the day tank because he could not read the fuel gauge. During a second interview at the same time as the observation, the Director of Facilities stated that there was no other way to determine how much fuel was in the tank. Basement 2) The evaluator observed the main electrical panel room was used to store three ceiling light fixtures, a ball, and a large 4 foot by 5 foot framed mirror. The items were located between the main electrical panel and the wall 3) The evaluator observed the main electrical panel room had 13 two-inch diameter penetration through the wall separating the main electrical panel room from the maintenance shop. 4) The evaluator observed the boiler room had a two-inch diameter penetration through a wall.	A 709	A 709 Plan of Correction #1 Cummings Pacific will install a new fuel gauge on the Emergency Generator fuel tank on 11/23/2018 This finding will be addressed on the July 2019 fire life safety Reg-4 testing please refer to: E 041Plan of Correction # 1 ATTACHMENT # 10 A 709 Plan of Correction # 2 All of the stored items were removed from the main electrical room on 08/01/2018 this findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department please refer to: K 511 Plan of Correction # 1 ATTACHMENT # 11 A 709 Plan of Correction # 3 The fire penetrations in the main electrical room were Sealed with fire retardant material on 07/31/2018 please refer to:K 321 Plan of Correction # 1 ATTACHMENT # 12 A 709 Plan of Correction # 4 The Two inch diameter penetration in the boiler room has been sealed with fire retardant material on 07/31/2018 please refer to: K 321 Plan of Correction # 2 ATTACHMENT # 13	11/23/2018 08/01/2018 07/31/2018 07/31/2018

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A 709	Continued From page 84 5) The evaluator observed the shop storage room corridor door had a missing lockset, creating a two-inch diameter penetration through the door. During an interview at the same time as the observation, the Director of Facilities stated that the penetration through the door was caused by the removal of a lockset, that he did not know who removed or when it was removed, and that the penetration should not be there. 6) The evaluator observed that in the fan room there was a fire extinguisher that was being hung by the base its hose onto a bracket. During an interview at the same time as the observation, the Director of Facilities acknowledged that the extinguisher was incorrectly placed in a manner that could damage the hose of the extinguisher. 7) The evaluator observed that in the medical records room, the second exit door was obstructed from fully opening by a shredding bin, a storage bin and a wire basket. During an interview at the same time as the observation, the Director of Facilities acknowledged that the exit door was obstructed from closing. 8) The evaluator observed that in the medical records room an exit sign was obstructed from view from the occupied center of the room. The sing was obstructed by file cabinets. 9) The evaluator observed the kitchen storage room had items store to the height of the ceiling, bypassing the required 18 inch height clearance	A 709	A 709 Plan of Correction # 5 The missing lock set in the shop storage room was replaced on 07/31/2018 please refer to: K 321 Plan of Correction # 3 ATTACHMENT # 14 A 709 Plan of Correction # 6 The fire extinguisher was replaced on 07/31/2018 with the right extinguisher type to fit in the existing bracket. Please refer to: K 355 Plan of Correction # 1 this will be monitored during the existing monthly fire extinguisher inspection by the engineering department Attachment # 15 A 709 Plan of Correction # 7 The Shredding Bin, Storage bin, and chart basket were permanently removed from the medical records on 07/31/2018 this findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department please refer to: K 211 Plan of Corrections ATTACHMENT # 16 A 709 Plan of Correction # 8 New self luminous exit signs have been ordered and will be installed by the engineering department on 12/17/2018 this findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department please refer to: K 293 Plan of Correction ATTACHMENT # 17	07/31/2018 07/31/2018 07/31/2018 12/17/2018

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A 709	Continued From page 85 between the bottom of the sprinkler head deflector and the top of storage. 10) The evaluator observed that at the corridor wall across from elevators 1 and 2, there was broken electrical cover plate at the wall mounted electrical receptacle. 11) The evaluator observed the fire extinguisher and hose cabinet located at the corridor wall next to elevators 1 and 2, was missing the handle that unlatches the cabinet door to access the fire extinguisher and hose. On 8/1/18 between 8:30 am and 2:30 pm the following conditions existed at the facility. 1st Floor Children Out Patient (COP) 12) The evaluator observed that at the COP waiting area there was no directional exit sign. During an interview at the same time as the observation, the Director of Facilities stated a directional exit sign would be placed. 1st Floor Kitchen 13) The evaluator observed eight of nine blow off caps were not placed on the nozzles of the suppression system located above the cooking range and deep fryer. During an interview at the same time as the observation, the Director of Facilities acknowledged the caps needed to be placed on the nozzles. 14) The evaluator observed one of one blow off	A 709	A 709 Plan of Correction # 9 A of the items were removed on 07/31/2018 in order to keep the required 18" clearance. this findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department please refer to: K 351 Plan of Correction ATTACHMENT # 18	07/31/2018
			A 709 Plan of Correction # 10 broken plate was replaced by the engineering department on 08/03/2018 please refer to: K 511 Plan of Correction # 2 ATTACHMENT # 19	08/03/2018
			A 709 Plan of Correction # 11 A new handle was installed in the fire hose /Fire Extinguisher cabinet on 07/31/2-2018 Please refer to: K 355 Plan of Correction # 2 ATTACHMENT # 20	
			A 709 Plan of Correction # 12 New self luminous signs have been ordered and will be installed on 11/30/2018 please refer to K 293 Plan of Correction please refer to; A 709 Plan of Correction # 8 ATTACHMENT # 17	11/30/2018
			A 709 Plan Of Corrections # 13 all of the blow off caps were put back 08/01/2018 cleaning crew was in-serviced on 10/17/2018 in proper hood cleaning and blow off cap replacement please refer to: K 324 Plan of Correction # 1 ATTACHMENT # 21	08/01/2018

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A 709	Continued From page 86 cap was not placed on the nozzle of the suppression system located above the cooking area. 1st Floor Administration 15) The evaluator observed that in the room identified as Clinic by a paper sign posted on the door there was one of six oxygen cylinder stored unsecured standing on the floor. During an interview at the same time as the observation, the Director of Facilities stated an oxygen storage rack would be obtained. 16) The evaluator observed that in the room identified as Clinic by a paper sign posted on the door there were 6 oxygen cylinders stored together and one cylinder on a crash cart without signage identifying which cylinders were empty and which were full. During an interview at the same time as the observation, the Director of Facilities acknowledged there was no signage, and stated that the crash cart was not functioning. 2nd Floor Administration 17) The evaluator observed in the conference room there was daisy chaining of extension cords by having a power strip that was connected to an extension cord that in turn was connected to a second power strip that was connected to a wall mounted electrical receptacle. 18) The evaluator observed that in the Information Technology (IT) room there were seven 1 inch diameter penetrations through the	A 709	A 709 Plan of Correction # 14 The blow of was was put back on 08/31/2018 the cleaning crew was in-serviced on 10/17/2018 in proper hood cleaning and blow off cap replacement please refer to: K 324 Plan of Correction # 22 A 709 Plan of Correction # 15 A new oxygen rack will be purchased and installed by the engineering department on 11/20/2018 A 709 Plan of Correction # 16 A new oxygen rack will be purchased and installed by the Engineering department on 11/20/2018 an "Empty" "Full" sign will be installed on oxygen rack A 709 Plan of Correction # 17 Extension cords were removed by the engineering department on 08/06/2018 A 709 Plan of Correction # 18 The fore penetrations in the server room and IT office have been sealed with Fire retardant material pleaser refer to: K 321 Plan of Correction # 4 ATTACHMENT # 23	08/31/2018 11/20/2018 11/20/2018 08/06/2018

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A 709	Continued From page 87 ceiling of the server room and one 1 inch by 2 inch penetration in the IT office. 2nd Floor Mezzanine 19) The evaluator observed the smoke barrier wall above the double doors between the elevator and the children hospital had two penetrations. During an interview at the same time as the observation, the Director of Facilities acknowledged the penetration.	A 709	A 709 Plan of Correction # 19 The fire penetration above the double doors between elevator and children in patient unit has been sealed with fire retardant material on 08/01/2018 please refer to: K 372 Plan of Correction # 3 ATTACHMENT # 24	08/01/2018
	2nd floor Children In Patient (CIP 2) 20) The evaluator observed the corridor door of room 212 failed to hold closed when shut. During an interview at the same time as the observation, the Director of Facilities stated the door failed to hold closed because the strike plate was misaligned.		A 709 Plan of Correction # 20 The door in room 222 has been adjusted on 08/02/1018 in order to have positive latching please refer to: K 363 Plan of Correction # 5 ATTACHMENT # 25	08/02/2018
	21) The evaluator observed a wall was constructed of plywood in non-sprinklered room 212. 3rd floor Adult In Patient (AIP 1)		A 709 Plan of Correction # 21 all of the existing plywood will be removed and the walls will be repaired to their original condition by 12/31/2018 please refer to: K 163 Plan of Corrections ATTACHMENT # 26	12/31/2018
	22) The evaluator observed there was a drop down fire door that would separate a nurses station from the charting room. There was no label on or around the door of inspection and testing of the door. During an interview at the same time as the observation, the Director of Facilities stated there was documented record of the door's current inspection and test.		A 709 Plan of Correction# 22 The drop down doors label was cleaned on 09/17/ 2018 and is visible now the drop down doors have been tested, inspected, and passed inspection on 08/09/2018, please refer to: K 300 Plan of Correction # 1 and # 2 ATTACHMENT # 27	08/09/2018

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A 709	Continued From page 88 During document review there was no documented evidence presented of the door being inspected and tested. 23) The evaluator observed a wall was constructed of plywood in non-sprinklered room 341. During an interview at the same time as the observation, the Director of Facilities stated that the drywall was replaced by plywood because the patients damage the drywall. 24) The evaluator observed a wall was constructed of plywood in non-sprinklered room 345. 25) The evaluator observed the corridor door of room 345 was missing. During an interview at the same time as the observation, the Director of Facilities stated that the door was removed about one week ago because it was broken and that they were waiting for the replacement door. 26) The evaluator observed the corridor door of room 347, a treatment room, was a Dutch door that did have an astragal where the top and bottom leaves meet. 27) The evaluator observed the fire barrier wall above the cross corridor doors near room 348 had a 1 inch diameter penetration. During an interview at the same time as the observation, the Director of Facilities identified the wall as a fire barrier wall.	A 709	A 709 Plan of Correction # 23 Please refer to: A 709 Plan of Correction # 21 A 709 Plan of Correction # 24 Please refer to: A 709 Plan of Correction # 21 A 709 Plan of Correction # 25 A new door was installed in room 345 on the week of 09/17/2018. please refer to K 363 Plan of Correction #4 ATTACHMENT # 28 A 709 Plan of Correction #26 A new metal astragal was installed on 08/01/2018 Please refer to: K 363 Plan of Correction # 3 ATTACHMENT # 29 A 709 Plan of Correction # 27 Fire penetration across Room 348 has been sealed with fore retardent material on 08/01/2018 Please refer to: K 372 Plan of Correction # 1 ATTACHMENT # 30	09/17/2018 08/01/2018 08/01/2018

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A 709	Continued From page 89	A 709		
	28) The evaluator observed there was a drop down fire door that would separate nurses station one from the day room. There was no label on or around the door of inspection and testing of the door. During an interview at the same time as the observation the Director of Facilities stated there was documented record of the door's current inspection and test. During document review there was no documented evidence presented of the door being inspected and tested.		A 709 Plan of Correction # 28 Please refer to: A 709 Plan of Correction # 27	
	29) The evaluator observed there was a drop down fire door that would separate nurses station one from the day room. The fire rating plate on the door was painted over and illegible.		A 709 Plan of Correction # 29 Please refer to: A 709 Plan of Correction # 27	
	30) The evaluator observed the corridor door of room 352 failed to hold closed when shut. During an interview at the same time as the observation, the Director of Facilities stated that the door failed to hold because the wrong type of strike plate was installed.		A 709 Plan of Correction # 30 A new door was installed on room 352 on the week of 09/17/2018 Please refer to: K 383 Plan of Correction # 2 ATTACHMENT # 31	09/17/2018
	3rd floor Adult In Patient (AIP 2) 31) The evaluator observed the smoke barrier wall above the ceiling separating the corridor from room 325, an office, had a 1 inch diameter penetration. During an interview at the same time as the observation, the Director of Facilities stated he could see the penetration.		A 709 Plan of Correction # 31 The fire penetration above ceiling separating the corridor from room 325 has been sealed with fire retardant material by the engineering department on 09/01/2018 please refer to K 372 Plan of Correction # 2 ATTACHMENT # 32	09/01/2018

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A 709	Continued From page 90 3rd floor Adult Out Patient (AOP) 32) The evaluator observed that in doctor office 8 there was daisy chaining of extension cords by having an extension cord connected to a power strip that was connected to a wall mounted electrical receptacle. 33) The evaluator observed that in a social worker office there was an extension cord that was passed under the carpet across a threshold that was connected to a wall mounted electrical receptacle. Document Review On 8/2/18 at 9:50 a.m., document review revealed the following: 34) Document review by the evaluator revealed there was no documented evidence of sensitivity of the smoke detectors. 35) Document review by the evaluator revealed there was no documented evidence that the transfer switch was being inspected and tested. During an interview at the same time as the document review, the Director of Facilities stated that the transfer switch was being tested monthly but that there is no documented evidence because the in house engineer was using the wrong form in the log that does not have a place for documenting the test. 36) Document review by the evaluator revealed there was no documented evidence that transfer time of emergency power was being tested.	A 709	A 709 Plan of Correction # 32 Extension cords will be removed for Dr's office # 8 by the engineering department on 10/26/2018 A 709 Plan of Correction # 33 Extension cord will be removed from the social worker office by the engineering department on 10/26/2018 A 709 Plan of Correction # 34 Smoke detector sensitivity testing was conducted on 09/19/2018 Please refer to:K 345 Plan of Correction ATTACHMENT # 33 A 709 Plan of Correction # 35 A new emergency generator/transfer switch test log that includes generator testing, transfer switch testing, and load transfer time has been implemented on 10/17/2018 and will be monitored by the engineering department on a monthly basis and it will be reported to the safety committee as part of the monthly QAPI report please refer to: E 041 Plan of Correction # 3 ATACHMENT # 34 A.709 Plan of Correction # 36 Please refer to: A 709 Plan of Correction # 35	10/26/2018 10/26/2018 09/19/2018 10/17/2018

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A 709	Continued From page 91	A 709		

During an interview at the same time as the document review, the Director of Facilities stated that the transfer time was between 8 to 10 seconds but that the transfer times were not being documented because there was no place on the log to document the times, and that the log would be recreated to include a place to enter transfer times.

37) Document review by the evaluator revealed there was no documented evidence that smoking regulations were adopted for smoking by patients, including smoking prohibited areas, designated smoking areas, which patients are prohibited to smoke, which patients are allowed to smoke, supervision of patients smoking, providing ashtrays of noncombustible material and safe design in all areas where smoking is permitted, and providing metal containers with self-closing cover devices into which ashtrays can be emptied readily available to all areas where smoking is permitted.

Review of the Smoke Free Environment Policy and Procedure, numbered 7080.7577.53 with a revised date of 3/1/2008, indicated that the purpose of the policy was to provide guidelines for governing a smoke free work environment, and that the scope of the policy was applicable to all employees. The policy had no indications in it for smoking by patients.

During an interview at the same time as the document review, the Director of Facilities stated that there is therapy smoking by patients at the AIP 1 smoking patio.

A 724	FACILITIES, SUPPLIES, EQUIPMENT	A 724		

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A 724	Continued From page 92 MAINTENANCE CFR(s): 482.41(c)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, and staff interviews, the hospital failed to ensure facilities and food service equipment were maintained to an acceptable level of safety for patients and staff; failed to maintain equipment to ensure safety and quality by not maintaining eyewashes, light diffusers, and light shields; failed to ensure the water faucet was working in the handwashing sink located inside the medication storage area at the children inpatient nursing unit (CIP); failed to ensure there was no white mineral deposit in the medication room in the Adult InPatient area 1 (AIP1). The deficiencies had the potential to hinder the practice of infection control; had the potential of any person that may have their eyes exposed to injurious materials to not have quick drenching or flushing of the eyes with water delivered at a tepid temperature, and for potential for shattered glass from lighting tubes and bulbs being contained. Findings: 1. During the tour of the kitchen on July 31, 2018 starting at 11:10 AM, during hand washing, the surveyor found the water temperature to be uncomfortably warm. There was no signage warning of the high water temperature. On August 1, 2018 at 10:20 AM during hand washing, the water temperature once again felt uncomfortably warm. In an interview with the DFS on August 1, 2018 at 11:00 AM about the high water	A 724	A 724 Plan of Correction # 1 Please refer to: A 701 Plan of Correction # 2 A new faucet mount eye wash station will be installed in the kitchen hand washing sink by the engineering department on 10/26/2018 this A 724 section findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department	10/26/2018

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A 724	Continued From page 93	A 724		

temperature, DFS stated he was not aware that the water temperature was high and acknowledged the water temperature would not allow food service staff to wash their hands long enough (20 seconds) as recommended. The DFS stated one of the registered dietitians (RD 1) had requested that water temperature be increased and so it was turned up by the facilities department.

A temperature check of the water showed it as 126.1 degrees Fahrenheit (F). Warm water is more effective than cold water in removing the fatty soils encountered in kitchens. An adequate flow of warm water will cause soap to lather and aid in flushing soil quickly from the hands. High water temperature that makes hand washing uncomfortable may lead to poor handwashing practices by food employees. According to the 2017 Food Code Section 5-202.12 (A) "A handwashing sink shall be equipped to provide water at a temperature of least 100 degrees F through a mixing valve or combination faucet". ASTM Standards for testing the efficacy of handwashing formulations specify a water temperature of 100 to 108°F. American Society for Testing and Materials (ASTM) , is an international standards organization that develops and publishes voluntary consensus technical standards for a wide range of materials, products, systems, and services.

Also attached to the faucet was an eye wash station. Higher water temperatures are harmful to the eyes and can enhance chemical interaction with the skin and eyes. The American National Standards Institute (ANSI) and the International Safety Equipment Association (ISEA) developed the American National Standard for Emergency

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 724	Continued From page 94 Eyewash and shower Equipment standards for the use, installation, operation and maintenance for emergency eye wash and shower equipment (ANSI/ISEA z358.1-2014) . ANSI/ISEA requirements for installation for plumbed emergency eye wash station include the eye wash station head "deliver ....tepid flushing water for 15 minutes". According to ANSI/ISEA Z358.1-2014, "tepid" is defined as a flushing fluid temperature conducive to promoting a minimum 15-minute irrigation period. A suitable range is 60 to 100 degrees Fahrenheit." Higher water temperatures are harmful to the eyes and can enhance chemical interaction with the skin and eyes. The tepid water is also to encourage compliance with the 15-minute irrigation period.	A 724		
	2. At 2:15 PM on July 31, 2018, the faucet in the 2-compartment sink was leaking hot water in the sanitizing compartment water. The constant dripping of the hot water into the solution had the potential to dilute the concentration, thereby making it ineffective. Sanitization of food service equipment and utensils removes (kills) potential disease causing organisms on the surface of the equipment.		A 724 Plan of Correction # 2 A new faucet was installed in the kitchen compartment sink by the engineering department on 08/03/2018 ATTACHMENT # 35	08/03/2018
	The facilities manager (FM) who was present during the observation, stated he was unaware but would repair the faucet by the next day. Observation on August 3, 2108 at 2:50 PM, showed the faucet had not been repaired.			
	3. At 3:47 PM on August 1, 2018, the temperature gauge for the dish machine was broken. The glass on the dial was cracked, chipped and temperature was stuck at 140 degrees F for both the wash and rinse cycles. The FSM flicked the temperature gauge with her finger, which moved		A 724 Plan of Correction # 3 A new temperature gauge was installed by dish washer Vendor the on 08/06/2018 ATTACHMENT # 36	08/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 724	Continued From page 95 the thermometer from 140 to 108 degrees F. The temperature gauge did not move after several wash cycles were observed. The manufacturer's recommended minimum water temperature for the machine for both wash and rinse cycles was 120 degrees F. Food service worker (FSW 3) who operated the machine stated the water temperature of machine is checked using a hand-held food thermometer. The temperatures are recorded while watching and listening to the different cycles. The FSM stated in a concurrent observation that she could not remember how long the thermometer had broken and when the food service staff started inserting a food thermometer in the water well to check water temperatures. The process was unsafe due an increased the risk of burn as the water splashed as it was flowing and circulating the well. 4. There was water spewing out leaking from the faucet in the chemical storage/janitorial area outside the kitchen. Attached to the faucet was a two paired hose bib connection, the hoses were red and black in color. A hose bib(b) is a "threaded faucet also known as a wall hydrant". The end of the red hose was inside a blue bucket on the floor with a dark brown solution, with bubbles resembling soap or detergent. The connection did not have an anti-siphon or back-flow prevention device. There was a significant build- up of a brown colored substance on the rack adjacent to the faucet, resembling rust. There was a similar colored substance on the horizontal bracket that held the water pipe to keep the faucet in place. The presence of rust could be an indication of the presence continued moisture in the area.	A 724	A 724 Plan of Correction # 4 A new faucet was installed in the janitorial area by the engineering department on 08/08/2018 a back flow device will be installed on11/23/2018 ATTACHMENT # 37	08/08/2018 & 11/23/2018

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A 724	Continued From page 96 According to the 2017 Food Code Section 5-203.14. "a plumbing system shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the food establishment, including on a hose bibb if a hose is attached .... and backflow prevention is required by law, by: (a) providing an air gap as specified under § 5-202.13 or (b) installing an approved backflow prevention device ..." The facilities director in an interview on August 1, 2018 starting at 3:50 PM indicated he was not aware of the leaking of the faucet. In an interview with the FSD on August 1, 2018 starting at 4: 00 PM, the FSD indicated he made reports to the facilities department about the various equipment that needed repairs. The FSD stated the reports were in form of email but was unable to provide evidence of the reports because he "does not keep email".	A 724		
	5. There were several light fixtures in the dish room had broken. This could be a source of cross-contamination of the clean dishes stored in the area. Section 6-202.11 (A) "light bulbs shall be shielded, coated, or otherwise shatter-resistant in areas where there is exposed food; clean equipment, utensils, and linens; or unwrapped single-service and single-use articles".		A 724 Plan of Correction # 5 Broken light fixtures have been replaced by the engineering department on 08/06/2018 ATTACHMENT # 38	08/06/2018
	6. Basement On 7/31/18 at 10:27 a.m., the evaluator observed that in the boiler room located in the basement, there was no documented evidence of testing of		A new eye wash station inspection log has been implemented on 10/17/2018 and will be monitored by the engineering department on a weekly basis and it will be reported to the safety committee as part of the monthly QAPI report. All faulty eye wash stations will be replaced on 10/26/2018 ATTACHMENT # 39	10/17/2018 & 10/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 724	Continued From page 97 the eyewash station. During the same observation the Director of Facilities had difficulty operating the pull knob to activate the eyewash station. At first on a trickle of water ran down the sides of the eyewash nozzles, then after a delay and struggling with the pull knob the Director of Facility was able to pull the knob to activate water flow from the nozzles of the eyewash station. During an interview at the same time as the observation, the Director of Facilities acknowledged the pull knob was stuck, and stated that the eyewash was supposed to be tested weekly, but that it had not been tested. On 8/1/18 between 8:30 a.m. and 2:30 p.m. the following conditions existed in the facility. 6. 1st floor kitchen The evaluator observed there was no documented evidence of testing of the eyewash station in the kitchen. When the Director of Facilities activated water flow from the nozzles of the eyewash station it was observed that the water flow was toward the wall and away from the person activating the eyewash. Closer observation revealed the water source was controlled by a single sensor valve and not by individual hot and cold water valves. At this time the temperature of the water was tested with a result of 120 oF (degrees Fahrenheit). During an interview at the same time as the observation, the Director of Facilities acknowledged the flow of the water was in the wrong direction, that the water temperature was 120 oF, and stated that there was no testing of	A 724	A 724 Plan of Correction # 6 A new eye wash station inspection log has been implemented on 10/17/2018 and will be monitored by the engineering department on a weekly basis and it will be reported to the safety committee as part of the monthly QAPI report ATTACHMENT # 39	10/17/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 724	Continued From page 98 the eyewash, that the eyewash would be removed because the water was too hot, and that a bottle eyewash would replace it.	A 724		
	7. The evaluator observed two of six ceiling light fixtures in the food preparation and cooking area had cracked diffusers/covers, and a 6 inch by 2 inch section was missing from one of the diffusers/covers. During an interview the Director of Facilities stated that ceiling light fixtures were going to be replaced		A 724 Plan of Correction # 7 All the cracked diffusers and covers have been replaced and shielded on the food preparation and cooking area on 08/06/2018 ATTACHMENT # 40	08/06/2018
	8. The evaluator observed three of six ceiling light fixtures in the dishwashing area were missing diffusers/covers exposing the glass tubes. No other form of light shields were observed at the light fixtures.		A 724 Plan of Correction # 8 All the cracked ceiling light fixtures in the dish washing area have been replaced on 08/06/2018 by the engineering department ATTACHMENT # 41	08/06/2018
	9. The evaluator observed one of two light shields was missing in the reach in refrigerator freezer unit at the kitchen dry storage area.		A 724 Plan of Correction # 9 Missing light shield in the refrigerator freezer will be replaced by the engineering department on 11/16/2018	11/16/2018
	10. On 8/1/2018 at around 4:10 p.m. during an inspection of the medication storage area (med room) at the CIP, there was a sink to the right of the entrance of the med room. The surveyor attempted to turn the faucets on; however, the faucet produced a tiny stream of water at maximum turn. The director of pharmacy (DOP) acknowledged the faucet was not functioning properly. During a concurrent interview, the unit charge nurse indicated the nurses had been using other sinks located elsewhere in the unit for an unknown amount of time.		A 724 Plan of Correction # 10 A new faucet will be installed on 11/08/2018 in the Medication room at the CIP Unit	11/08/2018
	11. During a tour of the facility's medication room on 7/31/2018 at 10:00 AM on the Adult InPatient			

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	054063	A. BUILDING _____ B. WING _____	08/03/2018

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A 724	Continued From page 99 area 1 (AIP1), the faucet appeared to have white mineral deposit on the end of the spout; there was no hot available from this faucet. At that time, the Charge Nurse acknowledged there was no hot water available from this faucet and the spout did appear crusted with some kind of mineral.	A 724	A 724 Plan of Correction # 11 A new faucet will be installed on 11/08/2018 in the AIP medication Room	11/08/2018
A 726	VENTILATION, LIGHT, TEMPERATURE CONTROLS CFR(s): 482.41(c)(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure there were temperature monitoring devices installed in the medication storage and preparation areas, such as medication rooms at the nursing units; and failed to ensure that lighting fixtures in the kitchen were maintained. This deficient practice had a potential affecting the integrity, stability, and/or potency of the products. Findings: a. During an inspection of the medication room inside the adult inpatient station 1 (AIP-1) on 7/31/2018 at 12:55 p.m., the director of pharmacy (DOP) confirmed there was no temperature monitoring device for the ambient temperature. During an interview on 8/1/2018 at 11:16 a.m., the DOP there was no documented daily monitoring	A 726	A 726 Plan of Correction # 1 A new temperature monitoring device will be installed by the engineering department in the medication rooms on 11/26/2018 this A 726 findings will be monitored during the safety tracers and reported to the quality management department on a monthly basis for work order completion status by the engineering department	11/26/2018

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A 726	Continued From page 100 of the ambient temperature inside the medication storage areas located at the nursing units; there were four such areas excluding the inpatient pharmacy. Review of the hospital policy and procedure, Temperatures: Storage, last reviewed 4/2018, indicated all drugs shall be stored at appropriate temperatures that do not exceed manufacturer's recommendation; the policy also indicated a controlled room temperature range. Review of another hospital policy and procedure, Storage of Medications, last reviewed 4/2018, indicated "Drugs shall be stored under the proper conditions of sanitation, temperature, light, moisture, ventilation,..." b. On 8/1/18 between 8:30 a.m. and 2:30 p.m. the following conditions existed in the facility. 3rd floor Pharmacy 1) The evaluator observed that in medication rooms, including the medication rooms at Adult In Patient (AIP) 1 and Children In Patient (CIP), there were tube type refrigerator/freezer thermometers with a -18 to 84 oF (degrees Fahrenheit) range in use to measure the ambient temperatures of the rooms. The evaluator observed that in the Pharmacy there was a dial type refrigerator thermometer with a -20 to 82 oF range in use to measure ambient temperature of the room. The evaluator's review of policy and procedure number 8390.09.04 for pharmacy temperature storage revised 10/2014 defined room	A 726	A 726 Plan of Correction # 1 new temperature monitoring devices will be installed on 11/20/2018 in all the pharmacy rooms	11/20/2018

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A 726	Continued From page 101 temperature and controlled room temperature as a temperature held between 59 and 86 oF. The temperature measuring instruments used to measure the ambient room temperatures in the medication rooms and the pharmacy did not have the range necessary to determine if the ambient room temperature was out of range. During an interview at the same time as the observations, the Director of Facilities stated that the ambient temperatures of the medication storage rooms are monitored daily by use of a laser temperature gun and recorded in the temperature log. On 8/2/18 at 11:09 a.m., the evaluator's review of the weekly temperature log book revealed that ambient room temperatures were monitored weekly not daily, and that the temperatures were monitored at the 3rd floor AIP 1 and 2 patient rooms and (nurses) stations' 1 and 2. There was no documentation that temperatures were monitored at the 2nd floor CIP including the CIP medication room and the Pharmacy at 3rd floor Outpatient. 1st floor kitchen 2) The evaluator observed that one of six ceiling light fixtures in the dishwashing area was not providing light. 3) The evaluator observed one of six ceiling light fixtures in the food preparation and cooking area was not providing light. 4) The evaluator observed there was no light in the reach in refrigerator freezer at the kitchen dry	A 726	A 726 Plan of Correction # 3 A new temperature Log to include the medication rooms was implemented on September 2018 and it has been monitored and recorded by the pharmacy department on a daily basis ATTACHMENT # 42 A 726 Plan of Correction # 4 Burned light bulbs in the dish washing are were replaced by the engineering department on 08/03/2018 ATTACHMENT # 43 A 726 Plan of Correction # 5 The burned light bulbs in the food preparation area were replaced by the engineering department on 08/03/2018 ATTACHMENT # 44	09/01/2018 08/03/2018 08/03/2018

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A 728	Continued From page 102 storage area. Closer observation revealed one of two light bulb was missing and one of two light bulb was burned out. During an interview at the same time as the observation, the Dietary Director stated that the bulbs would be replaced.	A 726	A 726 Plan of Correction # 6 The burned and missing light bulbs in the reach-in refrigerator in the dry storage room have been replaced on 08/03/2018 by the engineering department ATTACHMENT # 45	08/03/2018
A 747	INFECTION CONTROL CFR(s): 482.42 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.. This CONDITION is not met as evidenced by: Bases on observation, interview and record review the hospital did not meet the Condition of Participation in Infection control by failing to: 1. Designate a qualified infection control officer verified by experience, training, education, or certification. (Refer to A 0748) 2. Develop a system to prevent infections when it failed to monitor the cooling of several leftover or over-produced time temperature control for safety (TCS) food items (formerly potentially hazardous food). The facility did not have a system in place to ensure food was cooled to the appropriate temperature within the recommended time-frames. (Refer to A 749) 3. Monitor temperatures or utilize a cooling log to document the process. (Refer to A 749)	A 747	1. The CQI Director currently has a hiring action for a full-time Infection Control Preventionist (RN). Interviews will be conducted once qualified applicants have been received. In the interim the CQI Coordinator, LVN is acting in that capacity and has had online training in Infection Control Courses such as The Importance of Surface Disinfection and Departmental Housekeeping" completed 8/27/18 and will attend the two day LADPH Infection Control training on November 6-7, 2018.	8/27/2018 & 11/7/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 747	Continued From page 103 4. Ensure the director of the food service operation meet state educational requirements for the job including completion of a food safety course for managers. Only two of the ten employees had completed a food safety course contrary to state law that requires all food service works to complete a food handler's course. (Refer to A 749) 5. Provide a hospital wide infection control plan. (Refer to A 749) 6. Provide a safe and sanitary environment for patients, by failing to ensure the glucometer (a machine that checks the amount of sugar in the blood stream) was disinfected according to manufacturer's instructions. (Refer to A 749) The cumulative effect of these systemic problems resulted in the facility's inability to provide an effective hospital wide infection control program in a safe manner leading to increase probability of spread of infection.	A 747	5. The Annual Infection Control (IC) Plan was updated and signed on October 8, 2018. (Attachment W). 6. In-service will be held during change of shift with pre/post test. Glucometers will be cleaned in accordance to MFU before and after each use. Nurse Supervisor will use audit tool weekly and monitor the log for signature and date daily. The DON will be notified of deficiencies. Evidence of compliance will be monitored by CQI on a monthly basis via tracers and reported to the QAPI and Risk Management Committee; IC, MEC; and Governing Board.	10/8/2018 11/13/2018
A 748	INFECTION CONTROL OFFICER(S) CFR(s): 482.42(a) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to designate a qualified infection control officer (ICO) verified by experience, training, education, or certification.	A 748	The CQI Director currently has a hiring action for a full-time Infection Control Preventionist (RN). Interviews will be conducted once qualified applicants have been received. In the interim the CQI Coordinator, LVN is acting in that capacity and has had online training in Infection Control Courses such as The Importance of Surface Disinfection and Departmental Housekeeping" completed 8/27/18 and will attend the two day LADPH Infection Control training on November 6-7, 2018.	8/27/2018 & 11/7/2018

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A 748	Continued From page 104 Findings: During a conversation with ICO on 7/31/2018 at 11:20 AM, he stated that he was a Licensed Vocational Nurse (LVN) who had only been working at this facility for approximately 6 months; he affirmed he previously worked at this facility as a case manager. He continued on to say that as of this date he had not received any training or possess any training in infection control. When asked about the facility's policy on staff immunizations, he stated that he was not sure of PPD (a test used to diagnose latent tuberculosis, purified protein derivative) requirements and that the facility was currently developing its policy regarding influenza immunization. Lastly, he stated the facility was still studying quality indicators to be included in its QAPI program. A review of the personnel file of ICO, indicated no evidence of training in infection control.	A 748	The CQI Director currently has a hiring action for a full-time Infection Control Preventionist (RN). Interviews will be conducted once qualified applicants have been received. In the interim the CQI Coordinator, LVN is acting in that capacity and has had online training in Infection Control Courses such as The Importance of Surface Disinfection and Departmental Housekeeping" completed 8/27/18 and will attend the two day LADPH Infection Control training on November 6-7, 2018.	8/27/2018 & 11/7/2018
A 749	INFECTION CONTROL, PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, review of facility documents, manufacturer's instructions and staff interviews, the hospital failed to develop a system to prevent infections when it failed to monitor the cooling of several leftover or over-produced time temperature control for safety (TCS) food items	A 749	The CQI Director currently has a hiring action for a full-time Infection Control Preventionist (RN). Interviews will be conducted once qualified applicants have been received. In the interim the CQI Coordinator, LVN is acting in that capacity and has had online training in Infection Control Courses such as The Importance of Surface Disinfection and Departmental Housekeeping" completed 8/27/18 and will attend the two day LADPH Infection Control training on November 6-7, 2018. The online training certifications are currently located in the HR personnel file.	8/27/2018 & 11/7/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 749	Continued From page 105 (formerly potentially hazardous food). The food items including rice, chicken salad, gravy, potatoes and beans had been stored in the refrigerator from about twenty- four hours to as many as 19 days. The size of the food containers in which the food were stored varied from as little as a few servings to a large 6- quart container (about 8 inches tall) of cooked Spanish rice filled all the way to the brim. The facility did not have a system in place to ensure food was cooled to the appropriate temperature within the recommended time-frames. The Food Code provision for cooling "The food danger zone refers to temperatures above 41 degrees F and below 135 degrees F that allow the rapid growth of disease causing microorganisms that can cause foodborne illness. Foods held in the danger zone for more than .....6 hours ....may cause a foodborne illness if consumed". (Centers for Medicare and Medicaid, State Operations Manual) The facility did not monitor temperatures or utilize a cooling log to document the process. The director of Food service (DFS) responded to the surveyor on 7/31/18 at 11:46 AM about the lack of monitoring of leftover items. The staff failed to take the appropriate corrective actions including but not limited to discarding the items and ensuring temperature monitoring was taking place. More leftover or over-produced items were found in the refrigerator the following day on August 1, 2018 at 10:25 am. In addition, on August 1, 2018 at 11:30 AM, staff reheated a leftover chicken dish from the day before that was not monitored for proper cooling and attempted to serve to staff in the cafeteria before the surveyor stopped it from being served. The director of the food service operation did not	A 749	In-service was provided to kitchen staff on August 3, 2018. Pre/post test was also given to assess competency. (Attachment X).	08/03/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 749	Continued From page 106	A 749		

meet state educational requirements for the job including completion of a food safety course for managers. Only two of the ten employees had completed a food safety course contrary to state law that requires all food service works to complete a food handler's course. The food service manager who had completed a food safety course for managers and one of the cooks who had a food handler's card were the two employees who were compliant.

The failure of the hospital to monitor proper cooling of food, lack of staff knowledge and system to implement the process and the lack of corrective action on the part of the DFS after it had been identified the day before created an immediate jeopardy (IJ) situation that had the potential to result in food borne illness. This had the potential to cause food borne illness including death to all 33 patients and staff.

Immediate jeopardy was declared on 08/2/18 at 2:20 PM. The survey team informed the chief nursing officer of the immediate jeopardy situation. On 08/2/18 at 5:40 PM, the chief nursing officer provided an acceptable plan of action. The actions to remove the immediate jeopardy situation included discarding any leftover items, educating staff on discarding all leftover items after all meals are served without exception and staff training on food safety and bacterial growth.

The immediate jeopardy was abated (reduced in amount, degree or intensity) on August 3, 2018 at 3:05 PM when the facility was able to demonstrate knowledge of proper cooling of food, non-use of leftover items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 749	Continued From page 107 The facility also failed to supply a hospital wide infection control plan. In addition, the facility failed to provide a safe and sanitary environment for patients, by failing to ensure the glucometer (a machine that checks the amount of sugar in the blood stream) was disinfected according to manufacturer's instructions. This failure had the potential to result in cross-contamination between patients. Findings: 1. Inside the walk in refrigerator on July 31 at 11:45 AM, there were several containers of food that were leftover food from previous meals stored on the second shelf. There was a container of cooked rice dated 7/30, a container of ham also labeled 7/30. There was gravy in a container dated 7/29, a container labeled meatballs dated 7/26. There was also a large 6-quart container labeled Spanish rice filled almost to the brim. The observation was shared with DFS on July 11 at 11:48 AM. The surveyor requested for cooling logs to evaluate whether the items were cooled appropriately. DFS stated in the interview on July 31, 2018 at 11:48 AM, there were no cooling logs because the hospital does not save leftover items. On August 1, 2018 at 10:26 AM, the same gravy container dated 7/29, observed the day before in the refrigerator was on the shelf in the refrigerator. There were other leftover items observed stored on the top shelf in the refrigerator. There was salty mashed potato dated 7/26/18, diced potato dated 7/12/18, beans dated	A 749	1. Contracted with Professional RD vendor - Nutricopia (Attachment M) to provide menu for organization, Full time RD, and Director of Food Service to monitor food service personnels' day to day activities and develop quality assurance program (QAPI) Addressed in detail in staffing A618	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 749	Continued From page 108	A 749		

7/23/18, red potatoes dated 7/12/18, rice dated 7/29/18 another container of rice dated 7/30, garlic potatoes 7/26. The surveyor shared the observation with the DFS. The DFS stated on August 1, 2018 at 10:28 AM, the kitchen's priority was" to get breakfast and lunch out". DFS then directed Cook 1 to dispose of the leftover items. Cook 1 stated in the concurrent interview and observation on August 1, 2018 at 10:29 AM, he believed there was a 3- day grace period to use leftover items and they do not monitor or use any logs.

On August 1, 2018 at 11: 35 AM, there was a stainless steel pan in the oven. The Food Service manager stated item in the oven was the smothered chicken from the day before was being reheated for the cafeteria. FSM explained the entrée for the day was pork chop and the chicken which had been stored in the refrigerator was the substitute. The FSM stated there was no cooling log or monitoring of temperatures of the chicken dish completed.

A review of the hospital policy and procedure titled, "Receiving Food and Supplies" dated 4/26/17 under the subheading "Handling over-produced food, leftover food and extra food" states "over produced food which has not been on the steam table, may be stored for later use. For example, 10 extra portions of chicken may be wrapped, labeled, dated and refrigerated, after cooking is completed. Over-produced refrigerated foods must be used within 48 hours of the original cooking time; .....". The hospital policy did not guide the staff to monitor cooling leftover or over produced food items appropriately.

There were other deficient practices identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 749	Continued From page 109 during the survey for both campus related to improper food storage, improper food cooling, poor ice machine cleaning practices and general uncleanliness of the foodservice area, storage and preparation of food that could result in food poisoning and food borne illness, improper dish washing practices. 2. On July 31, 2018 at 11;45 AM, there were three boxes of coleslaw dated 7/3/18 stored in the refrigerator. All three boxes had manufacturer's use by date of 7/23/18. There was also a 20 lb. box of peas stored on the lower shelf in the refrigerator dated 7/20/18 with manufacturer's instructions to "Keep frozen until ready to cook". The DFS stated in an interview on July 31 at 11:47 am, he was not sure why the box of peas was in the refrigerator and not in the freezer. 3. There was a black substance observed along the length and width of walls on the caulking that sealed the stainless steel to the wall, on the grout lines of the wall tiles. The black substance resembled mildew (mold). The presence of molds could result in the contamination of stored food products and allergic reactions in patients, visitors and patients who are allergic to mold. The hospital did not ensure there was an effective system to identify unsanitary conditions in the dishwashing room. The kitchen staff did not identify a black substance on the walls in the dish machine area. These failures had the potential to affect all kitchen staff, other hospital staff, visitors and 33 patients that were admitted to the hospital through cross contamination of surfaces and air transmission. 4. During meal observation on August 1, 2018 at 12:10 PM the Adult in patient unit, Patient 38 had	A 749	Contracted with Professional RD vendor - Nutricopia (Attachment M) to provide menu for organization, Full time RD, and Director of Food Service to monitor food service personnels' day to day activities and develop quality assurance program (QAPI) Addressed in detail in staffing A618	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 749	Continued From page 110 asked for ice. The Mental Health Technician (MHT) who supervised the patients stated there was no ice available. Patient 38 continued to ask for ice stating "ice, ice, baby" with the request for ice getting louder. MHT scooped ice from the container that held the frozen dessert and provided to Patient 38. This ice could have been a potential source of contamination. 5. In an interview with the group of food service workers on August 3, 2018 at 2:55 PM, a random FSW explained that the hospital does not provide them with uniforms and the expectation is that if they need aprons they will have to purchase those themselves. FSW 3 who had an apron stated in an interview on August 1, 2018 at 2:15 PM, that he purchased the apron he had and takes it home to launder. Cook 2 who was also wearing an apron stated in an interview on August 1, 2018 at 10:47 AM, that the hospital did not provide him with the apron. Cook 2 stated that the plastic aprons melt when he gets close to the stove and heating equipment. The FSM who was present during the interview stated the hospital was" between vendors" and are currently not being provided with aprons. The Director of Food Services in an interview on August 3, 2018 at 2:25 PM, stated the hospital does not provide uniform or aprons. A review of the contracts between the previous and current laundry services provider, indicated that Contractor 1, (previous provider) provided kitchen towels, aprons, chef's coat, cook shirts and pants as part of the service (Exhibit B). A review of the contract for Contractor 2, (current provider) did not indicate if similar items were provided. There was a list of items as part of the contract but no aprons or kitchen towels were on	A 749	5. Hospital contracted with a new company, Republic Uniform, to provide these services. Hospital contracted with a new company, Republic Uniform, to provide these services.	01/01/2019 01/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054083	A. BUILDING _____ B. WING _____	08/03/2018

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KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

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A 749	Continued From page 111	A 749		

the list. In an interview with the Laundry Supervisor (LS) on August 3, 2018 at 3:00 PM, LS acknowledged that the current laundry services did not provide aprons.

The lack of aprons for food service staff exposed the patients to possible cross contamination of food from clothing. Dirty clothing may harbor diseases that are transmissible through food. Food employees who inadvertently touch their dirty clothing may contaminate their hands. This could result in contamination of the food being prepared. Food may also be contaminated through direct contact with dirty clothing. (Food Code Annex)

According to the 2017 Food Code Annex "All of the following control measures should be implemented regardless of the food preparation process used: ... ... Prevention of cross-contamination of ready-to-eat food or clean and sanitized food-contact surfaces with soiled cutting boards, utensils, aprons, etc., or raw animal foods.

6. There was water spewing out leaking from the faucet in the chemical storage/janitorial area outside the kitchen. Attached to the faucet was a two paired hose bib connection, the hoses were red and black in color. A hose bib(b) is a "threaded faucet also known as a wall hydrant". The end of the red hose was inside a blue bucket on the floor with a dark brown solution, with bubbles resembling soap or detergent. The connection did not have an anti-siphon or back-flow prevention device.
The lack of an anti-siphon or back flow device created a condition that could lead to the potential contamination of the hospital water supply with

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	054083	A. BUILDING _____ B. WING _____	08/03/2018

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A 749	Continued From page 112 the soapy contaminated visibly dirty water in the bucket. 7. The hand washing sink in the kitchen was located less than 6 inches from the drain board of the food preparation sink. There was no installed splash- guard to prevent soap or water from hands being washed from contaminating prepared food on the food preparation sink next to it. 8. During a conversation with ICO 7/31/2018 at 11:20 AM, he stated he was not sure the facility had an infection control (IC) plan but he had only been working at the facility for a few months. When asked what his duties up to this time were, he stated that he primarily had been building reports regarding patient infectious diseases developed or reported during their stays. He announced he would look for the IC plan which he believed the facility had. No IC plan was presented to surveyors by the end of the survey on 8/3/2018. 9. On 7/31/18 at 9:35 a.m., during a tour of the Adult Inpatient Unit (AIP) 2, Staff 8 was asked how she cleans the glucometer, she stated she sometimes cleans it with alcohol wipes. On 7/31/18 at 10:40 a.m., Staff 9 stated the glucometer is cleaned using alcohol or Sani-Cloth wipes. A review of the online manufacturer's instructions for cleaning the [Brand Name] Glucometer indicated the glucometer should be cleaned with several brands of disinfectant wipes, such as Super Sani-Cloth Germical Wipes and	A 749	8. The CQI Director currently has a hiring action for a full-time Infection Control Preventionist (RN). Interviews will be conducted once qualified applicants have been received. In the interim the CQI Coordinator, LVN is acting in that capacity and has had online training in Infection Control Courses such as The Importance of Surface Disinfection and Departmental Housekeeping" completed 8/27/18 and will attend the two day LADPH Infection Control training on November 6-7, 2018. The Annual Infection Control (IC) Plan was updated and signed on October 8, 2018. (see attached IC Plan).	8/27/2018 & 11/7/2018 10/8/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054093	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011

(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
A 749	Continued From page 113 CaviWipes.	A 749		