Lun Popking DRINTER PRINTED: 10/10/2018

		AND HUMAN SERVICES 8 MEDICAID SERVICES			11/2/	18			APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: .	(X2) MULT A. BUILDII	IPLE CONSTRUCT	TION			(3) DATE	SURVEY PLETED
		054083	B. WING		· · · · · · · · · · · · · · · · · · ·		.	08/	03/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRE 4211 SOUTH A LOS ANGELI	VALON BLVD			•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN I CORRECTIVE REFERENCED DEFICI	ACTION SHO FO THE APP	B QJUC		COMPLETION DATE
A 000	INITIAL COMMENT	rs	A 0	00		•			
÷	The following refle Department of Pub recertification surve	cts the findings of the lic Health during a ay.							
	Representing the D	epartment of Public Health:	•					•	
•	Surveyor 22458, Hi Surveyor 36329, Hi Surveyor 16281, Hi Surveyor 39840, M Surveyor 28851, Pi Surveyor 10933, Di	FE, Nrsing FE 1, REHS edical Consultant harmacy Consultant			•				
	Sample Size: 34								
	On 8/1/18 at 2:55 p the Dietary Consult the facility kitchen	.m., the team was informed by ant of adverse conditions in						ZEIS ROY	· · · · ·
	Officer (CNO) were	o.m., the facility Director, Assurance, and Chief Nursing Informed of the presence of Pardy (IJ) situation in Dietary Infection control.				·	CECHAED	-8 AH	
		o.m., a Plan of Action was rivey team by the Chief NO).							÷.;
	On 8/3/18 at 3:05 p Director of QA wen abated.	o.m., the Director, CNO, and a informed that the IJ was							•
		of Participation were not met					٠,		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Governing Body, 42 CFR 482.21 QAPI, 42 CFR 482.28 Food and Dietetic Services, 42 CFR

TITLE

(XX) DATE

Any deficiency statement ending with an electric (*) 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.

		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
		054083	B. WING		08/03/2018
,	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	atement of deficiencies Y must be preceded by full SC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A 000		ige 1 Wironment and 42 CFR 482.42	A0	00	
A 043	Infection Control. GOVERNING BODY CFR(s): 482.12		Α0	(A-043) The Governing Body failed to effect out its responsibilities for the operations of the control of the c	ectively carry
-	legally responsible If a hospital does n governing body, the for the conduct of t	effective governing body that is for the conduct of the hospital. ot have an organized a persons legally responsible he hospital must carry out the in this part that pertain to the		hospital.	
:	Based on interview supplied by the hor	is not met as evidenced by: v and review of documents spital, the Governing Body carry out its responsibilities for ne hospital.			
	development, impl of an effective, one data-driven Quality	Body failed to ensure the ementation, and maintenance joing, hospital-wide, Assessment and Performance PI) program. (Refer to A-0263)	·	 Refer to A-0283 and the corrective of stated therein. The Governing Board compliance evidenced by monthly rep the Director of Quality Management v Reports. 	will ensure porting by
	development, impl of an active hospit prevention, control	Body failed to ensure the ementation, and maintenance al-wide program for the , and investigation of infections e diseases. (Refer to A-0747)		Refer to A-0747 and the corrective at therein. The Governing Board will ensomption to the compliance evidenced by various representations such as bi-monthly IC necessaries.	orting
	hospital's food and and staffed by ade meet the nutritiona accordance with p acceptable standa	Body failed to ensure the I dietetic services was directed quate qualified personnel to il needs of the patients in ractitioners' orders and rds of practice. Failure to and safety practices that		MEC, QAPI, and Governing Board. 3. Refer to A-618, A-619, A-620, A-62 A-630, A-724, and A-749) and the co- actions stated therein.	

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

		O MEDICAL SULVEY		_	MO MO, ODOG-OGO I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
'		054083	B WING	o P. A. 1973-1974 Main ann Antain ann an ann ann an ann ann ann ann an	08/03/2018
NAME OF	PROVIDER OR SUPPLIER	And the second		STREET ADDRESS, CITY, STATE, ZIP CODE	**************************************
Lemman man				4211 SOUTH AVALON BLVD	
KEDKEN	COMMUNITY MENTA	AL HEALTH CENTER		LOS ANGELES, CA 90011	
(X4) (D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
· A 043		ge 2 idiate jeopardy situation. A 619, A 620, A 621, A 629, A	A 04	13	
	630, A 724, A 749)				,
	medical staff has w for appraisal of eme	lody failed to ensure that the ritten policies and procedures ergencies, initial treatment. appropriate. (Refer to A-093)		 There is currently a policy reference #203: Emergencies - Medical which was redistributed at the policy of the staff on October 15, 2018, along with the "Prior Medical Emergencies". (Attachment A) 	uted to .
	resulted in the Gove	ect of these systemic problems erning Body's failure to ensure health care to patients in a			
A 091	EMERGENCY SEF CFR(s): 482.12(f)	RVICES	20 A	 A091 PLAN OF CORRECTION: In-service ER Kit location and contents and of contents. 	10/30/2018
	Emergency Service	98		Contact oxygen and regulatory company to service on oxygen in Nursing Station for easy	
	Based on observa review, the facility f	This STANDARD is not met as evidenced by: Based on observations, interview, and record eview, the facility failed to ensure patient safety and well-being, by failing to:		accassibility in case of ER. 3) In-services will be held on October 30, 201 change of shift. Staff will sign and keep log. 4) Nursing Managers will monitor ER kit revie oxygen monthly for Licensed Nurse signature	8 at w and rs,
	AIP 2-were aware of equipment, which I	Adult Inpatient Unit (AIP) 1 and of a change in the emergency had the potential to result in y response for patients.		Nurse Manager will audit monthly and eval process: (Attachment B)	uate the
	for one of two oxyg and that the tanks order to prevent de an emergency, and maintenance was o	tenance date had not expired ten (O2) tanks on AIP Unit 2, were easily accessible, in all of the event of two out of two O2 tanks on the tent Unit (CIP).			•
¥	3. Ensure staff on	the CIP Unit were checking the		3. The crash cart have been removed from the	se CIP Unit 10/17/2018

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

PRINTED: 10/10/2018 FORM APPROVED OMB NO. 0938-0391

CEN1	'ERS FOR MEDICARE	& MEDICAID SERVICES					<u> </u>	<u> 1938-0391</u>
STATEM	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILT		ONSTRUCTION		(X3) DATE COMI	SURVEY PLETED
	•	054083	B. WING				08/0	3/2018
NAME	OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE	, ZIP CODE		
KEDF	EN COMMUNITY MENT	AL HEALTH CENTER		, , .	SOUTH AVALON BLVD ANGELES, CA 90011			
(X4) I PREF TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD O THE APPROP	BE	(X5) COMPLETION DATE
Α0	Emergency Cart of prevent inadequate	age 3 n a regular basis, in order to e supply of supplies and event of a medical emergency.	A	091	and emergency kits ar of standard compliand weekly and monthly tr CGI team.	a is being moni	tored by	ence
	(AIP) 2, when RNZ Emergency Cart, Ithe desk in the Nu- cart was supposed pharmacy staff me to restock it. Seve- stated the Emerge Nurses Station. Ri orange box from A Ambu Bag, stetho and stated the Em- replaced by the bo	a.m. on Adult Inpatient Unit It was asked the location of the ne pointed to an area behind reses Station, and stated the it to be there, then stated the lay have taken the cart in order rail other staff members also ency Cart was kept in the N 1 then obtained a plastic NP Unit 1 that contained an scope, and blood pressure cuff tergency Cart had been ex several months ago because the to an emergency.						
	(AIP) 2, two O2 ta Valuables Closet, Chief Nursing Offi were supposed to the Nurses Station	a.m. on Adult Inpatient Unit nks were observed in the which was kept locked. The cer (CNO) stated the tanks be located against the wall of and not locked up, in order to be event of an emergency.					,	
- And the state of	of the Treatment I Unit with RN 5, a on the Emergency medications were however, there we in the cart were al	35 a.m., during an observation Room on Children's Inpatient review of the Signature Sheet y Cart indicated the emergency checked on a daily basis, as no indication that the supplies so being checked. RN 5 stated a checked every day.		*	,			

Two out of two O2 tanks in the Treatment Room

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING	·	08/03/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Office 13 and the second secon
KEDREN	COMMUNITY MENTA	AL MEALTH CENTED	1	4211 SOUTH AVALON BLVD	
1 200 ft 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Without I mail	we imported the contract of th		LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD DE COMPLETION
A 001	Continued From pa	ana A	8.0	04	
N QQ I	2 17 1700	-	A O	3.1	
,	had expired mainte	nance dates. Kiv o dates had expired, and that he			
		aintenance Department.			
A 093	EMERGENCY SEF		ΑO	93 Reference policy #2033 - Emergencies -	vledical which 10/18/2018
	CFR(s): 482.12(f)(2	2)		was redistributed to staff on October 15,	1018, along
	te .			with the "Procedure for Medical	
		ces are not provided at the ning body must assure that the		Emergencies". (Atlachment A)	
		ritten policies and procedures		A093 PLAN OF CORRECTION:	11/20/2018
		ergencies, initial treatment,		1) in-service policy	
	and referral when a			 In-service staff at change of shift or pol pre-test and post-test. 	l¢y,
	MILL COMABINATOR :			3) Monitor in the event of ER, all actions v	vill be
		s not met as evidenced by: v and review of documents		evaluated on a case by case basis.	
		pital, the hospital medical staff		4) DON will audit and evaluate each ER a	ituation.
	falled to adopt writt	en policies and procedures for			
		f medical emergencies,			
		, initial treatment, referral and dividuals with emergencies.		•	
	transportation or ni	aviduais will ethergencies.			
	Findings:	·			
•	•				
		d on 8/2/18 at 1400 hours with			
		or. When asked about the handling persons with medical			
		Medical Director stated that a			•
	physician is always	on-call and all medical staff			
	are certified in Bas	ic Life Support (BLS). If		•	
		resent on-site, they will directly			
	participate in emer	gency care, whereas during nly on-call coverage is			
		es call the on-call physician for		1	
	direction. He adde	d that if the on-call physician			
		immediately, he usually		. Reference policy #2033 - Emergencies	
	serves as Dackup a	and the nurses can call him.		: was redistributed to staff on October 1	i, 2018, along
	Interview conducte	d on 8/3/18 at 0955 hours with		with the "Procedure for Medical Emergencies".	
1		for Adult Inpatient Unit 1 (RN		(Attachment A)	

CENTERS FOR MEDICARE & MEDICAID SERVICES ON						
STATEMENT	CS FOR MEDICANE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	OMB NO, 0938-0391 (X3) DATE SURVEY COMPLETED	
		054083	B. WING	The second secon	08/03/2018	
NAME OF	PAOVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
	AMBERSISSISMI SAPEST	ii iibai tii oriited		1211 BOUTH AVALON BLVO		
KEDREN	COMMONIT MENT	al Health Center		LOS ANGELES, CA 90011		
(X4) IO PREFIX TAG	(EACH DEFICIENC	tement of deficiencies y must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
A 093	duty (RN2). When address and care f conditions, RN1 st individual, stabilize on-call, and if need individual to an act all nursing staff are	age 5 another registered nurse on questioned about how they for persons in emergency ated she would first assess the notify the physician on duty or led, call 911 and transfer the lute care hospital. She added BLS-certified and trained to 2 agreed with the stated		Reference policy #2033 - Emergencies - M was redistributed to staff on October 15, 20 with the "Procedure for Medical Emergence (Altschment A)	018, elong	
	and/or Disaster Priceads: "(a) In the case of to the degree permited regardless of departices, shall be reasonably possible to save a patient from the physician shall man communicate proconcerning the neassistance by Merappropriate Clinical emergency has permade avallable, si Director with respirat the Hospital." "(b) in the event on non-Physician shall reasonably posior to save a patier non-Physicians should be proconcerning the mergency has permade available, si Director with respiration on the same proconcerning the proconc	Bylaws Section 7.5 Emergency ivileges, dated October 2014, an emergency, any Physician, nitted by his or her license and artment, staff status, or Clinical experiments are permitted to do everything le to save the life of a patient or rom serious harm. The ike every reasonable effort to inpity with the Medical Director ed for emergency care and inbers of the Medical Staff with all Privileges, and once the assed or assistance has been nail defer to the Medical sect to further care of the patient of an emergency, any all be permitted to do whatever sible to save the life of a patient of the form serious harm. Such nail promptly yield such care to so of the Medical Staff or other a or she becomes available.		Reference policy #2033 - Emergencies - It was redistributed to staff on October 15, 2 with the "Procedure for Medical Emergen (Attachment A)	018, along	
		l hours [3:30 p.m.], when ide a written policy and			ĸ	

	<u>23 LOD MEDIOWRE</u>	A MEDICAID SERVICES	·	10000000000000000000000000000000000000	· •	MB NO.	<u> 1920-8660</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				Survey Leted
		054083	B WING	}	**************************************	08/0	3/2018
NAME OF I	PROVIDER OR SUPPLIER		- Commence of the Commence of	S 1	FREET ADDRESS, CITY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		42	211 SOUTH AVALON BLVD		
		- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		L.(OS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF THE PROPERTY OF T	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	0E	(XS) COMPLETION DATE
A 093	emergencies, the D stated she was uns was available but s	tal's management of medical lirector of Quality Management ure whether a written policy he would look for it. Indicated she did not identify	A	093	Reference policy #2033 - Emergencies - Mi was redistributed to staff on October 15, 20 with the "Procedure for Medical Emergenci (Attachment A)	18, along	h 10/15/2018
A 117		NOTICE OF RIGHTS	A	117	A117 PLAN OF CORRECTION:		10/15/2018
	, , ,				1) Information signs are developed with cor	rect agend	у .
	A hospital must inform each patient, or when appropriate, the patient's representative (as				telephone numbers and addresses to voice	and	
		lient's representative (as a law), of the patient's rights, in			receive written complaints.		
	advance of furnishing	ng or discontinuing patient			2) Signs have been placed in visiting areas	tion and	
	care whenever pos				•	85 YIGH	
	This STANDARD IS	s not met as evidenced by:			as each telephone on the unit.		
		ion and interview, the facility			3) Visual check will be made on 11PM/7AM shift daily		
	failed to display the	correct phone number and			to ensure signs are maintained on the unit.	These will	
		e agency responsible for complaints as per regulation.			be signed by the Charge Nurse on duty.		
		ed to ensure the legal			4) Nurse Manager will monitor sign placem	eni an	
	guardian of an unde	arage patient received and			Adult and Children's Units.		
	acknowledged the page documents.	patient's rights and related			*Parent's/legal guardian of minor patients s	hall sign	
	dudiniono.				that they received and acknowledged "Pati-	ant's Right	s"
	Findings:				and related documents.		
	AM, it was noted the the wall in the received addressing complated Department of Man	e facility on 7/31/2018 at 8:20 at the information located on otion area of the lobby for ints was only for the ital Health; no address was mia Department of Public			On October 15, 2018, additional signs were in the reception area of the lobby, break ar waiting rooms of the inpatient and outpalls noting the contact information for addressic complaints for the California Department of Health.	ea, and nt areas ng	10/15/2018
	(DONPC) stated sh	rector of Nursing Primary Care ne did not know the correct given the correct address and		- a			

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

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	4	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		Committee some 5 mm
		054083	e. WING		08/03/2018
	ROVIDER OR BUPPLIER COMMUNITY MENT	AL HEALTH CENTER	42	REET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTH AVALON BLVD DS ANGELES, CA 80011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	d be completion [
A 117	regarding patient of changes would be 2. Review of Patie indicated the patie	vhich to report complaints are; she stated the appropriate	A 117		•
A 131	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. PATIENT RIGHTS: INFORMED CONSENT CFR(a): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make		A 131	I) in-service staff on policy of informed continuous ment in Treatment Plan.	11/13/2018 nsent and
And the state of t	informed decision The patient's right or her health statu planning and treat or refuse treatmet construed as a m provision of treatmet	decisions regarding his or her care. ent's rights include being informed of his alth status, being involved in care and treatment, and being able to request treatment. This right must not be d as a mechanism to demand the of treatment or services deemed y unnecessary or inappropriate.		 2) Consent will be kept with the MAR. 3) In-service with pre/post test during shift 4) Chart audits on NOC shift delily. 5) Will maintain a log and evaluate audit reby Nurse Manager. 	
	Based on record failed to inform th proposed antipsy class of psychiatr illnesses such as	is not met as evidenced by: review and interview, the facility e patient (Patient 3) of a chotic medication (those in a ic drugs used to treat major schizophrenia and bipolar ink to reduce delusional thought,	,	· · · ·	! !

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO</u>	D. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		CONSTRUCTION	(X3) D/	ATE 6URVEY OMPLETED
		054083	B. WING		уму болууу улан тогон ууулын на арабок багш родундага	01	B/03/2018
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		***************************************
KEDREN COMMUNITY MENTAL HEALTH CENTER				I SOUTH AVALON BLVD B ANGELES, CA 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE	COMPLETION DATE
A 131	Continued From pa	ge 8	Α	131			
	hallucinations, and	physical/emotional ecreasing the patient's					
	Findings:						
	"[Facility Name] Co- medications" indica (agreed to treatment following medication used to bipolar disorder), A anxiety and sleeple insomnia or panic conservations.	riew of Patient 3's file, the insent to receive psychotropic ated the patient had consented int) on 6/22/18 to take the ins: Latuda (antipsychotic treat schizophrenia and tivan (typically used to treat issness), Restorii (used for disorder). There was no int for the medication Seroquel.					
	an order was writte	an orders for Patient 3 showed on on 6/22/18 for Seroquel 100 mouth (PO) at bedtime (qhs).					v.
·	this patient on 6/22	ministration Record (MAR) for 1/18 revealed that he had been 0 mg PO at 21:00 on 6/22/18.		\$	•		
	8/1/18 at 9:00 AM,	n with the Charge Nurse on he attested that the el should have been listed on nt to treat form.					,
	Procedure "Information Medications", a volument to receive after being informe accept or refuse to	ity Name] Policy and ed Consent to Antipsychotic luntary patient shall give psychotropic medications only id of the patient's right to eatment with the proposed as the benefits and side cation.		: : : :	``.		

PRINTED: 10/10/2018 FORM APPROVED OMB NO. 0938-0391

	CENTER	IS FOR MEDICARE	& MEDICAID SERVICES	·				0830-0381
1	STATEMENT	OF DEFICIENCIES F GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA- IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			054083	a, WING	Maria Maria		08/0	03/2018
ľ	NAME OF P	ROVIDER OR SUPPLIER			STF	REET AODRESS, CITY, STATE, ZIP CODE		
	KEDREN	COMMUNITY MENTA	al Health Center		****	1 South Avalon BLVD 18 Angeles, CA 90011		
ľ	(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X8) COMPLETION DATE
	A 144	Continued From pa	age 9	А1	144			
١		·	CARE IN SAFE SETTING		44			
l		CFR(s): 482.13(c)(•		•		
		The patient has the setting.	right to receive care in a safe			,		
		Based on observa	is not met as evidenced by: tlon, interview, and record falled to ensure a safe vided for patients, by failing to:	•				
		(anything which co rope, or other mate or strangulation) in	ty was free from ligature risk uld be used to attach a cord, erial for the purpose of hanging patient care areas, which had ult in patient self- harm or			Weekly CQI tracers are conducted to patient care areas are free of ligature an environmental risks. In addition, all EQC incident reports are required to complate environmental risk assessment as a part investigation process.	d other related an	8/27/2018
		the reports were comes coordination of and facility staff. The result in incomplet events. Findings: 1. On 8/3/18 at 9:2 Employee Bathroo Unit (CIP), located Station, revealed at	reports and investigations of completed, and ensure there of the reports by Security Staff his fallure had the potential to e investigations of adverse 25 a.m., an observation of the om in the Children's Inpatient I across from the Nurses a drain pipe on the toilet, and a The door was partially open,	ed, and ensure there sports by Security Staff ure had the potential to stigations of adverse and categorized by the severity and/or complete the incidents (Attachment C). The Patient Safety Manager, and/or Director of Facilities Manager, and/or Direct			h local policinager, Riek lenagement rimmediate nie are trac complexity er analysis is investigation redingly and Riek erning of going to stem (PSR),	ked of s conducted . an
		and did not have a	a security lock. , RN 5 stated there was always the Nurses Station who would	•		which will eliminate the paper reporting allow the investigation process to be m in addition, this will increase reporting to be able to print various reports.	ore efficient	:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES						ON BMC	. 0938-0391
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M Comment	• ~^*******************			421	I1 SOUTH AVALON BLVD		
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A 144	Continued From pa		A 1	44	A144 PLAN OF CORRECTION:		11/13/2018
		ale and Female Rest Rooms were regular drain pipes on			1) Request all code locks on all staff bathr	ooms.	
	the toilets and sinks				2) Follow-up with Engineering Department	Į.	
	· · · · · · · · · · · · · · · · · · ·	and already and talk and a second talk		4	3) Nursing staff will escort patients to bath	room If	
	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			!	needed.		
				(4) Staff will check bathroom door to ensur	e It is locke	d.
	facility did not have ligature risk.	a policy that addressed		ı	All staff will monitor every shift.		
	facility indicated the by both Security Sto of the reports were	ew of Reports provided by the reports were being submitted aff and the facility staff. Some not completely filled out, and estigation outcomes.					
	Case Manager, Ind Children's Inpatient mental health work The patient's room hospitalization, time notified, and wheth physician, had beel indicated the patier However there was regarding whether	7/2/18, and completed by a loated Patient 43 (on the Unit) had alleged that a er (MHW) had choked him. number, age, reason for a the Case Manager was er the patient was seen by a n left blank. The report it's physician was notified no further information the alleged perpetrator was final outcome of the					
ж	registered nurse (R family member had 44 had told him she by her roommate. that he had called to another staff me Patient 44's safety.	6/28/18 and completed by a kN), indicated Patient 44's I called and stated that Patient 3 had been sexually assaulted The family member also stated the prior night and had spoken mber regarding his concern for The report further indicated other expressed concern for					

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VEDDEN	CONTRACTION SACRET	AL HEALTH CENTER		4211 SOUTH AVALON BLVD	
KEDKEN	COMMONITY MENT	AF LICHTIU OFISIER	<u> </u>	LOS ANGELES, CA 90011	NAMES AND ASSESSED OF THE OWNER OF THE OWNER,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLETION
A 144	she be transferred review of the incide had assured the fa was safe, and wou concerns to the su report that address notified, and wheth physician, were bo of the RN who con There was no indicate facility.	ige 11 to the RN, and requested that to another room. Further ent report indicated that the RN mily member that the patient lid report the family member's pervisor. The section of the sed whether the physician was er the patient was seen by a th checked "No." The signature holeted the report was illegible, sation of further investigation by a.m., during an interview, the	A1	144	
A 175	Director of Quality regarding how repstated she has been month, and that the for the prior year. Set Patient Safety Mar QA Director then simplement a meth receives from secuwas not sure if the yet. She added the indicate whether they had already be PATIENT RIGHTS SECLUSION CFR(s): 482.13(e) The condition of the secued must be licensed independ that have complete	Assurance (QA) was asked orts were handled. The Director on at the facility just over a ere was no one in the position. She also stated that there is no nager or a Risk Manager. The tated she has been trying to od for handling the reports she unity staff and floor staff, and reports had been investigated at there was no system to be reports were still open, or if ween investigated. ERESTRAINT OR (10) The patient who is restrained or monitored by a physician, other ent practitioner or trained staff ad the training criteria specified this section at an interval	A	We now have a full-time Patient Safety staff. All incidents are tracked and categoreverity and/or complexity of the incider analysis (Attachment C) is conducted (it deemed necessary. Once investigations they are closed out accordingly and more are given at the QAPI and Risk Manage MEC, and Governing Board. We are curprocess of going to an Electronic Patien Reporting System (PSR), which will elin paper reporting system and allow the in process to be more efficient. In addition will increase reporting and allow us to it various reports and see which reports a pending, and closed.	orized by the its and further a. RCA) if are completed withly reports ment Meetings, rently in the t. Safety white the vestigation this

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KEDREN	COMMUNITY MENTA	AL HEALTH CENTER			11 SOUTH AVALON BLVD DS ANGELES, CA 80011		
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A 175	Based on interview failed to follow accemonitoring patients Assessment and m to prevent injury to restraint can be dispossible. Findings: According to an "Er Medication Physicia Patient 21 on 7/29/medications were ophysician on 7/29/1	ge 12 s not met as evidenced by: r and record review, the facility repted practice with regard to who were under restraint. onitoring should be performed the patient and ensure the continued as soon as mergency Psychoactive an Order Form" completed for 18 at 08:20, the following rdered and validated by the 8: Haldol, Benadryl, Ativan; as to be given one time for	A 1		A175 PLAN OF CORRECTION: 1) In-service staff on Seclusion and Restrat regarding every 15 minute monitoring and documentation. 2) Pre/Post testing for Seclusion and Restrat documentation, and Denial of Rights. 3) Audit daily on NOC shift Seclusion and it Denial of Rights, and Emergency Med List. 4) Nurse Manager will evaluate audits and feedback. (Attachment R)	aints Polic Restraints,	у
	The "Emergency U: Flowsheat" asserts monitored and mon minutes after admit was no apparent do in the patient's file. During a short conv. Nurse on 6/2/18 at that there should be monitoring. A review of the facilitited, "Seclusion ar stipulated that a lice trained and compermust assess the parestraint use and every series."	rersation with the Charge 11:40 AM, he acknowledged a documentation of this lity's policy and procedure at Restraint Use" (page 5 of 7) caused staff member who is tent in the use of restraints attent at the initiation of the very 15 minutes thereafter in needs and physical condition					

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A 263	QAPI CFR(s): 482.21		A2	263	
1	maintain an effectiv	develop, implement and re, ongoing, hospital-wide, assessment and performance am.			
	the program reflect hospital's organizat hospital department those services furn arrangement); and	erning body must ensure that is the complexity of the complexity of the its and services; involves all its and services (including lished under contract or focuses on indicators related outcomes and the prevention edical errors.			
	The hospital must evidence of its QA	maintain and demonstrate PI program for review by CMS.			
And the state of t	Based on interview hospital failed to e hospital-wide, data ensure quality of or facility did not mee	is not met as evidenced by: v and record review, the stablish and maintain a -driven QAPI program to are and patient safety. The t the Condition of Participation e and performance program by			
	assurance and per program to ensure safety. There was shows measurable program data for v	aintain a hospital-wide quality formance improvement (QAPI) quality of care and patient no ongoing program that a improvement in indicators and which there is evidence that it outcomes. (Refer to A 0273)	•	The QAPI program was implemented up Director of Quality Management's arrival June 18, 2018. The first meeting was held July 24, 2018. Meetings are held every for Thursday of the month. (Attachment D).	l which was id on

2. Establish and maintain a hospital-wide quality

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

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 263	assurance and perl program to ensure safety. There was r hospital to identify of and setting of priori improvement activity DATA COLLECTIO	formance improvement (QAPI) quality of care and patient no QAPI program data for the apportunities for improvement ties for its performance ties. (Refer to A 0283)		263	2. The QAPI program was implemented Director of Quality Management's arriv June 18, 2018. The first meeting was July 24, 2018. Meetings are held every Thursday of the month. (Attachment D). The QAPI program was implemented Director of Quality Management's arr June 18, 2018. The first meeting was	al which was reld on fourth upon the val which wa	7/24/2018
	(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.				July 24, 2018. Meetings are held ever Thursday of the month. (Attachment D).		
	indicator data included the relevant data, submitted to, or rec Quality Improveme (2) The hospital mu (i) Monitor the eservices and quality (3) The frequency	ist use the data collected to iffectiveness and safety of					
	This STANDARD i	s not met as evidenced by;	,			·	

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		· 4:P4:P4: AELYED	ŀ	4211 SOUTH AVALON BLVD		}
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A273	hospital-wide qualit improvement (QAP care and patient as program that show indicators and prog	age 15 stablish and maintain a ity assurance and performance PI) program to ensure quality of afety. There was no ongoing ys measurable improvement in gram data for which there is il improve health outcomes.		273 The CAPI program was implemented up Director of Quality Managements antive June 18, 2018. The first meeting was he July 24, 2018. Mastings are held every (Thursday of the month. (Attachment D).	il which was ald on	/24/2018
	Findings:					1
	p.m., with the Direct When requested to QAPI Committee, the Management was adocuments, stating yet exist. She reported to the state of the program was in playing the state of	conducted on 8/2/18 at 3:50 ctor of Quality Management, o provide the minutes of the the Director of Quality unable to produce the g that the committee does not orted that her position had since the previous director left go, and no definable QAPI ace at the hospital when she wer a month ago. She addednity developed a QAPI plan, and icess of training the staff in on determining quality hering data. The Director ished a document titled, ealth QAPI Program - Resource 18. Review of the document to that defines the structure and a QAPI program in general.	.			
A 283	GUALITY IMPRON CFR(s): 482.21(b): (b) Program Data (2) [The hospital r]	VEMENT ACTIVITIES)(2)(ii), (c)(1), (c)(3)	· ' ·	283 The QAPI program was implemented undercor of Quality Management's and June 18, 2018. The first meeting was houly 24, 2018. Meetings are held every Thursday of the month. (Attachment C) there are two PI activities starting base collected. PI charters are attached. (Attachment D).	val which was neld on r fourth). Currently	7/24/2018

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A 283	Continued From pa	ige 16	A	283			
	performance improversible (ii) Focus on high problem-prone area (iii) Consider the severity of problems (iii) Affect health quality of care. (3) The hospital multiperformance improvementing those measure its successible.	ust set priorities for its vernent activities that n-risk, high-volume, or as; incidence, prevalence, and s in those areas; and outcomes, patient safety, and ast take actions aimed at					
	Based on interview hospital failed to es hospital-wide quality improvement (QAP) care and patient sa program data for the opportunities for impriorities for its perfactivities.	s not met as evidenced by: v and record review, the stablish and maintain a y assurance and performance l) program to ensure quality of fety. There was no QAPI he hospital to identify provement and setting of formance improvement				,	
	Findings:						
	the Director of Quai requested to provid Committee, the Director was unable to product that the committee	d on 8/2/18 at 1530 hours with dity Management. When le the minutes of the QAPI ector of Quality Management uce the documents, stating does not yet exist. She osition had remained vacant					

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

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A 283	ago, and no definal at the hospital when month ago. She addeveloped a QAPI process of training on determining quadata. The Director document tilled "[Fr Program - Resourc Review of the docu defines the structur	director left about two years ble QAPI program was in place in she first arrived just over a ded that she has recently plan, and has begun the the staff in each department lity Indicators and gathering subsequently furnished a acility Name] Health QAPI e Guide" dated 7/5/18. ment indicated an outline that e and components of the	A:	283	The QAPI program was implemented upon Director of Quality Management's arrival June 18, 2018, The first meeting was held July 24, 2018. Meetings are held every for Thursday of the month. (Altachment D).	l which was d on	7 <i>1241</i> 2018 ;	
A 297	defines the structure and components of the QAPI program in general. 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.		A 297		Currently there are two PI activities startir on QAPI data collected. PI charters are at (Attachment D). Evidence of standard cor will be monitored by CQI on a monthly ba reported to the QAPI and Risk Manageme Committee; MEC; and Governing Board.	itached npliance sis and	09/27/2018	
4. 15	be proportional to the hospital's services (2) A hospital may, and implement an inexplicitly designed to quality of care. This development, does measurable improvement project reasons for conduct measurable progres (4) A hospital is not	cts conducted annually must ne scope and complexity of the						

CENTER	43 FUR MEDICARE	8 MEDICAID SERVICES			OMB NO. 0938-0391		
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A 297	Continued From particular continued from particular continued for the continued for the continued from the c	_	A 29	7			
	Based on interview hospital as part of performance improto have documents projects are being care and patient sa projects for review. Findings: An interview was common with the Direct When requested to GAPI Committee, Management was documents, stating yet exist. She repremained vacant a about two years as program was in playing the program was and gate of the partment of indicators and gate subsequently furning "[Facility Name] Heresource Guide" of document indicate structure and commit general.	is not met as evidenced by: v and record review, the its quality assessment and evement (QAPI) program failed ation what quality improvement conducted to ensure quality of afety. There were no QAPI conducted on 8/2/18 at 15:30 ator of Quality Management. by provide the minutes of the attention of Quality unable to produce the a that the committee does not be previous director left ace at the hospital when she are a month ago. She added atty developed a QAPI plan, and coess of training the staff in being data. The Director shed a document titled attent 7/5/18. Review of the d an outline that defines the ponents of the QAPI program August 3, 2018 starting at 9:12 ad dieititians (RD1 and RD2)		The CAPI program was implemented Director of Quality Management's a June 18, 2018. The first meeting wa July 24, 2018. Meetings are held ev Thursday of the month. (Attachment D).	rrival which was s held on	7/24/2018	

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A 297	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 morthly audits are presented to the administrator		A	297	Currently there are two PI activities starting QAPI data collected. Pi charters are attached		09/27/2018
					Including one from Dietary Services, Eviden	ce of	
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				standard compliance will be monitored by C	QI on a		
		tled "Sanitation Report"			monthly basis and reported to the QAPI and	Risk	
				Management Committee; MEC; and Govern	ing Board		
A 395			A	395	A395 PLAN OF CORRECTION:		11/06/2018
	CFR(s): 482.23(b)	CFR(8): 462.23(0)(3)			1) In-service Registered Nurses on Admission		
		must supervise and evaluate			Procedure and Documentation regarding C	are Plan	
•	the nursing care fo	r each patient.			meeting patient needs.		
Ì	This STANDARD	is not met as evidenced by:			2) in-service pre/post test regarding Admiss	ilon	
	Based on record in	eview and interview, the neure a registered nurse would			Documents, skin assessment and signs an	i symptom	\$
	assess each patie	nt on admission to develop and			of contagions skin infastations.		
		riate care plan that meet the			3) Audit delly on NOC shift audit document	atlon, Plan	
'	patient's need (Pa	uent 31).			of Care for assessment or treatment of con	tegions	
	Findings:				skin conditions.		
	Review of Patient	31's admission record indicated			4) Nurse Manager will evaluate audits and	provide	
	transferred from a hospital (GACH).	mitted on 7/23/2018 and was nother general acute care Review of a laboratory report GACH indicated that on			feedback,		
	7/22/2018, a day t	pefore this hospital admission,			*		į
	Patient 31 had ski	n rash confirmed to be scables condition caused by an			•		,
	infestation of mite	B).			!		ì
	On 8/3/2018 at an concurrent interview	ound 2:10 p.m. during a ew with the chief of nursing			1		,

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

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	i alleisatus	al Health Center		4211	ET AODRESS, CITY, STATE, ZIP CODE SOUTH AVALON BLVD ANGELES, CA 90011			
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A 395 A 431	(CON), CON confin physician orders an did not indicate an plan for Patient 31's MEDICAL RECORI	med that Patient 31's nd interdisciplinary plan of care assessment nor a treatment s contagious skin condition.		395 431				
	that has administra records. A medical	nave a medical record service tive responsibility for medical I record must be maintained evaluated or treated in the		,	•			
	Based on observat review the facility fa	is not met as evidenced by: tion, interview, and record alled to meet the Condition of adical Record Service by failing			·			
	contained an accur reconciliation of per	t's clinical record (Patient 15) rate description of the patient's reconal belongings before he m the facility. (Refer to		·				
	Patient 17's clinical Patient 19 contains	eted Discharge Summary in file; verify that the record of ad complete, legible, and rs. (Refer to A-0450)		:				
	(Patients 11-15, 17	patients' medication orders -18, 23) were promptly e prescribing physician. (Refer		*				
*** ***	consent form of Pa	perly executed informed itlent 31 for use of an cation was initiated by the	1	i				

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	<u>0938-0391</u>
STATEME	NT OF DEFICIENCIES 4 OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WING	шинин	янськи и меромуну при	08/	03/2018
NAME C	F PROVIDER OR SUPPLIER	- The state of the		នា	REET ADDRESS, CITY, STATE, ZIP CODE	.h.r.combattananana	***************************************
				42	11 SOUTH AVALON BLVD		
KEDR	EN COMMUNITY MENT	AL HEALTH CENTER			OS ANGELES, CA 90011	TO TO SECURE	
(X4) (I PREFI TAG	(KEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
A43	The cumulative eff	oner. (Refer to A-0466) ect of these systemic problems	A	431			;
A 43	resulted in increase errors and/or patie	ed probability of medication nt safety.	• A	43R	All nations medical record antices must be i	acibla	2 PACIO PIA P.
A 44	CFR(s): 482.24(b) The hospital must each inpatient and must be accurately properly filed and it hospital must use identification and rensures the integriprotects the security. This STANDARD Based on observatively, the hospital medical record wanto. Findings: On 8/1/2018 at arc inspection of the himedication storage access, after the presence of the diather were two dratted drawers may comedications or medications or medications or medications. In	maintain a medical record for outpatient. Medical records / written, promptly completed, retained, and accessible. The a system of author ecord maintenance that try of the authentication and try of all record entries. Is not met as evidenced by: ation, interview, and record al failed to ensure patient's a accurately written (Patient earea designated for after-hour harmacy is closed) in the rector of pharmacy (DOP), were with signage indicating ontain patients' own dication brought from home iside one of those drawers, it paper bag marked with		138	All patient medical record entries must be I complete, dated, times, and authenticated or electronic form by the person responsible providing or evaluating the service provides consistent with hospital policies and proced Medical records staff routinely audits charts deficiencies based on an established audit. The deficiencies are flagged and the percer non-compliance deficiencies are noted in a report to Quality Assurance. These non-cofindings will be reported monthly to the Med Director and Director of Nursing of the AIP unit. Along with copies of the issues identifinon-compliance. A Medical Records Review Guideline Tool was implemented on 10/19/ensure records were complete, ignite, and suthenticated in accordance with local policiend federal regulatory standards. (Attachment E)	in written a for d, ures. I dentifying oriterie, ntage of monthly mpliance lical hospital ed as n 18 to	10/19/2018
		15's medical record indicated					ı

CENTE	<u> 3 FOR MEDICARE</u>	& MEDICAID SERVICES		·	Oi	<u> </u>	1980-8890
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WING	j	ichaaria dhaha ahinki ishi ki ishi ki kalainki da ishi ishi ki ki ishi ka asab	08/0	3/2018
NAME OF I	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	WANTED BY THE PARTY OF THE PART	
KEDREN	COMMUNITY MENT,	al Health Center	-	l .	211 South Avalon Blvd OS Angeles, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	i Be Nate	(X5) COMPLETION DATE
A 438	Review of Patient 1 Summary dated 7/1 an entry by a regist discharged with all	n discharged on 7/17/2018. 5's Interdisciplinary Discharge 17/2018 at 4:05 p.m. revealed ered nurse stating "Patient personal belongings."	A	438			
A 450	CFR(s): 482.24(c)(All patient medical complete, dated, the written or electronic responsible for proprovided, consister procedures. This STANDARD is Based on interview failed to make certained to make certained to ensure Patient 19 and authenticated to ensure Patient 1 Summary was complying a record physician admissional telephone by a regional procedure in the medications on the following: Ativa control anxiety or sto treat sleeplessness.	D SERVICES 1) record entries must be legible, med, and authenticated in a form by the person widing or evaluating the service at with hospital policies and as not met as evidenced by: and record review, the facility aln that patient's medical contained complete, legible, orders. The hospital also failed 7's interdisciplinary Discharge apleted. review of Patient 19's file, an orders were taken by interest nurse and written in the admitting diagnosis for specified psychosis. Among dered upon admission were an (medication typically used to deeplessness), Restoril (used ess), and Geodon (atypical cation that treats schizophrenia		450	All patient medical record entries must be in complete, dated, itmes, and authenticated it or electronic form by the person responsible providing or evaluating the service provided consistent with hospital policies and proced Medical records staff routinely audits charts deficiencies based on an established audit of The deficiencies are flagged and the percent non-compliance deficiencies are noted in a report to Quality Assurance. These non-confindings will be reported monthly to the Med Ofrector and Director of Nursing of the AIP hunit. Along with copies of the issues Identified non-compliance. A Medical Records Review Guideline Tool was implemented on 10/19/1/19/19/19/19/19/19/19/19/19/19/19/1	n written i for i, ures. identifying itleria. idage of monitalical iospital id das v i8 to y, state	10/19/2018

		& MEDICAID SERVICES	***		<u>O</u> M	<u> 18 NO. (</u>	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X8) DATE COMP	BURVEY LETED
		054083	B. WING	******		08/0	3/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	******	
KEDREN	COMMUNITY MENT	AL HEALTH CENTER			211 South Avalon Blvd OS Angeles, CA 80011	.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
A 450	A subsequent orde 6/21/18 at 7:58 PM open seclusion alo were to begin 6/21/6/21/18 at 11:50 PI the ordering physic During a brief conv. Nurse on 8/2/18 at orders should have of the origination of According to the "Procedures - Meditelephone or verbaby authorized persuch orders should patient's progress countersigned by two (2) working da 2. During a review interdisciplinary Diform) was blank. On 8/3/2018 aroun Nursing (CON) prefectronic version which indicated two nursing and rehabientry each. Howev blank, including psecial services.	wing the ordering physician orders. r for this same patient on indicated that an order for any with cuffs/ankiets restraints (18 at 7:50 PM and end M. There was no indication that clan had signed the orders. rersation with the Charge (1205 PM, he stated that the abeen signed within 48 hours if the order. Facility Name) Policies and cation Administration", I orders are to be written only onnel for emergency situations; is be documented in the notes and these orders he ordering physician within		450	The Medical Records Supervisor will impleme monitor training staff on the importance of aud date / time/MD eign noted on all orders. Implion 10/16/18, with Revised Medical Record Charl Audit Tool (Attachment D), the Director Rehabilitation has provided a list of the AIP interdisciplinary Treatment Teams to assist M Records in Identifying when missing/not compared to the information of the non-compliance deficiency. This will ensure treatment is clearly documented and eigned disciplines. In addition, emails will be sent to disciplines responsible and courtery copied to Medical Director, Director of Nursing. Director Rehabilitation and Director of Social Services Monitoring/Tracking Procedure: Bi-weekly austaff 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 eigned by all disciplines, Ernalls will be earn to discipline responsible. Emails will be earn to discipline responsible and carbon copied to Medical Director, Director of Nursing, Director of Rehabilitation and Chief of Social Services. Individual Responsible: Medical Records Signature and electric Services. Individual Responsible: Medical Records Signature and electric Services.	diting the amented of ledical olisted/med of ure by all or of s, dit of	10/18/2018
	the Interdisciplinar	y discharge summary should				www.www.more	(4)444

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION .	(X3) DATE COMP	SURVEY LETED
		054083	B. WING	Der Blücken Norfart Norfbrond unseiner seinen Artes Seiten unsein der der stelle der der der der der der der d	08/0	3/2018
KEDREN		AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETION DATE
A 450	Continued From pa have been complet discharge. Patient 7/26/2018.	age 24 led prior to the patient's 17 was discharged on	A 450	Adult Inpetient Treatment Teams Tool Implemented on 10/15/18		10/15/2018
,	SIGNED CFR(s): 482.24(c)(All orders, including timed, and authent practitioner or by a responsible for the a practitioner is act law, including scop policies, and medic regulations. This STANDARD Based on interview hospital falled to en authenticated and/practitioner prompi 17, 18, 23, 9, 10, 3	g verbal orders, must be dated, icated promptly by the ordering nother practitioner who is care of the patient only if suching in accordance with State e-of-practice laws, hospital cal staff bylaws, rules, and is not met as evidenced by: we and record reviews, the asure medication orders were or signed by the prescribing liy (Patients 11, 12, 13, 14, 15, 5 and 36). This deficient ential for medication errors	A 454	Content of Record: Orders Dated & Signed. Medical Records Clerk will/review chart on a signatures/and flag for physicians signature Clerk will also inform charge nurse of misser If after 3 days and still no signature Medical Director and Director of Nursing will be infor This process will be implemented on 10/22/ QAPI measure has been put in place to tract trand improvement in this area. Monitoring/Tracking Procedure: Bi-weekly r Individual Responsible: Medical Records Si	s, g signature. med. 2018. A k and eview	10/22/2018
	1. Review of Paties order dated 7/27/2 was a telephone o	nt 11's physician admission 018 at 6:20 a.m. indicated it rder and the prescriber had not order as of 8/1/2018.		Appropriate disciplinary action will be t MEC pending peer review.	akenby the	10/28/2018
	order dated 7/21/2 was a telephone o	nt 12's physician admission 018 at 6:42 p.m. indicated it rder and the prescriber had not order as of 8/1/2018.	* t .	Appropriate disciplinary action will be t MEC pending peer review.	•	
	3. Review of Patie	nt 13's physician admission 018 at 6:30 p.m. indicated it		3. Appropriate disciplinary action will be to MEC pending peer review.	ken by the	10/26/2018

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, -		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WING)		08/0	3/2018
	PROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTH AVALON BLVD DS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full LSC identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH GORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(XB) COMPLETION DATE
A 454	Continued From powas a telephone of authenticated the	age 25 rder and the prescriber had not order as of 8/1/2018.	Α	454			i de la companya de l
	order dated 6/12/2 was a telephone of	nt 14's physician admission 1018 at 8:35 p.m. indicated it order and the prescriber had not order as of 8/1/2018.			4. Appropriate disciplinary action will be taked MEC pending peer review.	en by the (10/26/2018
	order dated 7/6/20 a telephone order	nt 15's physician admission 118 at 8:10 p.m. indicated it was and the prescriber had not order as of 8/1/2018. Patient 15 n 7/17/2018.		,	5. Appropriate disciplinary action will be tak MEC pending peer review.	en by the	10/26/2018
	order dated 7/19/2 was a telephone of	ont 17's physician admission 2018 at 1:00 a.m. Indicated it order and the prescriber had not order as of 8/1/2018.			Appropriate disciplinary action will be ta MEC pending peer review.	ken by the	10/28/2018
	order dated 7/19/2 was a telephone of	ont 18's physician admission 2018 at 9:30 p.m. Indicated it order and the prescriber had not order as of 8/1/2018.			7. Appropriate disciplinary action will be ta MEC pending peer review.	ken by the	10/26/2018
,	order dated 7/22/2 was a telephone of	ent 23's physician admission 2018 at 6:55 p.m. indicated it order and the prescriber had not order as of 8/1/2018.			8. Appropriate disciplinary action will be tal MEC pending peer review.	ken by the	10/28/2018
	chief of nursing (C	40 a.m. during an interview, the CON) indicated the prescribers riders within 24-48 hours.					·
	Verbal/Telephone 4/2018, Indicated by a prescriber (e subsequently auti	spital policy and procedure, Orders, last reviewed in "Orders that are not written .g., verbal or telephone) shall be nenticated (verified) and the prescribing practitioner			· .		******************************

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE BURVEY COMPLETED	
		054083	B. WING	· · · · · · · · · · · · · · · · · · ·	08/03/2018
	PROVIDER OR SUPPLIER COMMUNITY MEN	TAL HEALTH CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 4211 SOUTH AVALON BLVD LOS ANGELES, CA 80011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LBC (DENTIFYING INFORMATION)	ID PREPI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
A 454	within 48 hours. T	age 26 he prescribing practitioner must ate, and time authenticating the	· A4	54	
	indicated a telephoshampoo, dictated	e closed record for Patient 9 one order for lice-killing i on 6/20/18 at 1800 [6 p.m.], physician but not dated and		Appropriate disciplinary action w MEC pending peer review.	dil be taken by the 10/28/2018
		orders for Lithium and Zyprexa, at 1658 [4:58 p.m.], route of s omitted.			
	Informed consent drugs was not cor	for treatment with psychotropic npleted.			4000000
	indicated a telephoand Benadryi, dict	closed record for Patient 10 one order for Haldol, Ativan, ated on 6/17/18 at 1000 hours, ated by the physician but not		10. Appropriate disciplinary action with MEC pending peer review.	MILL DE TEXEN DY UTE 11/20/2010
,		one order to discharge the n 6/22/18 at 0900 hours, was	: .		
		cactive medication physician 6/17/18 at 1030 hours, was not		,	
	8/3/18 Indicated a Ativan and Restor	ient 35's medical record on telephone order for renewal of ii, dictated on 8/1/18 at 0800 I by the physician but not dated		Appropriate disciplinary action MEC pending peer review.	will be taken by the 10/28/2018
		ne order for renewal of Ativan ited on 7/25/18 at 0800 hours,		•	

PRINTED: 10/10/2018 FORM APPROVED

CENTER	CO FUR IMEDICARE	& WEDICAID SERVICES			<u> </u>	JMB NU	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL A. BUILD	•	CONSTRUCTION	(XS) DAT CON	E SURVEY IPLETED
		054083	B. WING		*	08/	03/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KEDBEN	COMMINITY MENT	AL HEALTH CENTER		42	11 SOUTH AVALON BLVD		
MADINER		AE DEMEI D CENTEN		LC	OS ANGELES, CA 90011		- t
(XA) ID PREFIX TAG	(EACH DEFICIENC	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ζ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
A 454	Continued From pa	nae 27	A4	, 54			·
	was not authentica	*	77	U-4	* **		
A 468	indicated a telepho on 7/30/18 at 1915 authenticated. Physician Admission at 1715 hours, were at 1715 hours, were According to the MR egulations, Section Cotober 2014, "One telephone shall be dictated per the natifie time and date to Telephone orders from sectusion must be psychiatrist or consuppropriate, within orders must be significant or consuppropriate.	nt 36's medical record ne order for Ensure, dictated [7:16 p.m.], was not on Orders, dictated on 7/27/18 e not authenticated. edical Staff "Rules and on 6.5 Clinician Orders", dated ders dictated over the signed by the person to whom me of the Clinician, indicating he order was given. or medications, restraints and signed by the attending sulting physician, as 24 hours, all other telephone ned within 48 hours." CORD: INFORMED	A 4		A468 Content of Record: Informed Consent, Medical records in auditing will review or more thoroughly to ensure procedures treatments specified by the medical staff necessary signatures. If not signed will be forwarded to the Medical Director. Individual Responsible: Medical Records Monitoring/Tracking Procedure: 81-weekly Tool: Medical Records Chart Audit Tool (Attachment E).	and nave the Supervisor	
	appropriate:) Properly executed procedures and tre medical staff, or by	4)(v) ocument the following, as informed consent forms for atments specified by the Federal or State law if re written patient consent.					
	Based on interview hospital failed to en complete an inform	s not met as evidenced by: vs and record reviews, the sure prescribing practitioner sed consent for the use of an cation on Patient 31.				· ·	

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

STATEMENT AND PLAN C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERACLE (XD) PLAN OF CORRECTION IDENTIFICATION NUMBERS		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING	·	·	08/03/2018
	PROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER		421	reet address, city, state, zip code 11 Bouth Avalon Blvd 98 Angeles, ca 90011	
(XA) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG	'IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRO DEFICIENCY)	ON (X5) LD BE COMPLETION)PRIATE DATE
A 466	Continued From pa	age 28	A	466		•
	Findings:					•
	indicated an order long-acting antipsy the treatment of ps milligrams intramus	31's physician's orders of invega Sustenna (a chetic medication indicated for chiatric conditions) 234 scularly (into the muscle). This n 8/1/2018 at 11:30 a.m.				·
	Atypical Long-Actin	31's Medication Consent for ng Anti-Psychotics form, dated clude the medication name		•		
A 500	interview, the chief antipsychotic cons- completely with the medication prescri		A	600		
	§482.25(b) Standa	ard: Delivery of Services			, ,	
	biologicals must be distributed in accor standards of practi Federal and State This STANDARD	rdance with applicable ice, consistent with law. is not met as evidenced by: ition, interview, and record			•	
	committee (P&T, a responsible for the	rmacy and therapeutics a committee that would be a establishment and evaluation of the use of .		;	The P&T Committee will be held in a with local policy. Memorandums will be individuals that are expected to attend, mandatory attendance.	sent to those

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			<u></u>	-	1830-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		054063	B, WING	Manage and Associated as		08/0	3/2018
NAME OF F	ROVIDER OR SUPPLIER		COLUMN TO SERVICE STATE OF THE		REET ADDRESS, CITY, STATE, ZIP CODE	,,,,,,,,	
KEDREN	COMMUNITY MENT	al Health Center			nn Bouth Avalon Blyd Os Angeles, ca 90011	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
A 500	Continued From pa medications and of policy.	age 29 . hemicals) would be held as per	Αŧ	500	2. Policy No. 8390.11.01 Dispensing Gener (Attachment F) and Policy No. 8390.11.08	After	10/18/2018
	described the curridispensing.	r and procedure accurately ant process of medication		<i>;</i>	Hours Dispensing (Attachment G) was upon reflect the organization's current process and procedures. This was distributed to all staff responsible for dispensing and in medications on 10/18/2018.		
	retail pharmacy wo	ped medication dispensed by a buld be returned if the patients ad within seven days.	dispensed by a 3. Nursing and Outpatient Pharmacy to meet on Ciober 23, 2018, to address this, and develop a P&P.		10/23/2018		
	4. Ensure patient's own/home medications be returned to the patient on discharge.				An in-service will be provided by the inp- Pharmacy Director to all Nursing Staff on 1		10/25/2018
	Findings:						
	interview, and a co- hospital's P&T cor- twelve months, the confirmed the con- year of 2017 (on 3 once thus far in 20 records consisted presented at the n	t 12:55 p.m. during an encurrent review of the mmittee records for the past a director of pharmacy (DOP) mmittee had met twice in the 1/24/2017 and 11/15/2017) and 018 (on 4/13/2018). The P&T of the agendas and exhibits neetings; however, the minutes for these past meetings vailable.	i		The P&T Committee will be held monthly policy was updated to reflect this change, memorandums will be sent to those individual are expected to attend. This will be mattendance.	in addition, Juals	10/19/2018
	Pharmacy and The reviewed in 4/201 Therapautics Con Hospital Medical staff of at least three p the director of nursecretary, and the of the meeting's neeting's neeting neeting's neeting neeting's neeting neeting neeting neeting's neeting neet	pital policy and procedure, erapeutics Committee, last 8, indicated "The Pharmacy and inmittee exists as part of the Staff. It is an advisory group of The committee shall consist hysicians, one pharmacist, rsing service, medical staff administrator The recording injutes shall be the me Medical Staff secretary and					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: .		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		054083	B. WING,		08/03/2018	
	PROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 80011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of Deficiencies / Must be preceded by full sc (Dentifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
A 500	the hospital. The co	ige 30 I in the permanent records of ommittee shall meet at regular equently than quarterly or four	A 5			
	the director of phar pharmacy hours we from 9 am to 7 PM locker (a medicatio after-hour access, and maintained floor	12:40 PM, during an interview, macy (DOP) stated the ere Mondays through Fridays. The hospital had a night in storage area designated for after the pharmacy is closed) or stock at each nursing unit.		 The pharmacy hours are from 9:00 a. In addition, the hours are stated in the in the Policies and Procedures. The hours next to our DEA license within the pharm (Attachment H). 	troduction of are also posted	
	interview, the DOP of the after-hour ni- every Friday. Review of the hosp	und 4:30 PM, during an stated the nursing usage logs ght locker would be reviewed bital's After Hours Medication		if any of the 30 doses mentioned were between the hours of 5:30 p.m. and 7:0		
	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			they are not removed incorrectly. To ad removel of medication that could have a removed during pharmacy hours, a medication was distributed to the nursing staff on 9 3:12 p.m. (Attachment I). This memoral addressed the fact that only authorized permitted to enter and remove medicatinght locker. The DON has also address the staff and has fully reviewed and upof authorized RNs. In addition, we will the Nursing Training on 10/25/2018, which	dress any still been morandum /24/2018 at ndum RNs are ions from the sed this with dated the list he holding a	
	nurse should acce removed from the confirmed there we during pharmacy h removed at the sai The DOP acknowl were removed sho	e DOP stated only a registered ss and document medications night locker. The DOP also ere multiple doses removed ours, and many doses me time for multiple patients. edged most of these doses rity before or after pharmacy orther confirmed the access to		this as well. In regards to the LVN, mentioned by the appropriate disciplinary actions have bein accordance with local policy. In additionabling has been scheduled with Sec Dickinson for 10/16/2018 to discuss a	eën taken Jilon, a Jon	

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-03				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. * *	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY LETED	
	i	054083	B. WING	AND THE RESIDENCE OF THE PARTY	08/0	3/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	My - 100	- AND THE PERSON NAMED IN COMMENTS	
KEDREN	COMMUNITY MENT	AL HEALTH CENTER		4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X6) COMPLETION DATE	
A 500	and for immediate	ige 31 ould be limited to after hours use; there were overlapped in the floor stock and the	A6				
	Hour Dispensing, is indicated " The his supply of medication entering the pharm pharmacist is not a supplies shall be in nurses When me patients after pharmacist registered nurses is medications from the patients after the patients after pharmacist shall re-	ital policy and procedure, After ast reviewed in 4/2018, aspital shall established a uns which is accessible without acy during hours when the valiable. Access to the miled to designated registered edications are ordered for macy hours, the designated would obtain the necessary the after-hours medication ilents'] immediate needs. The concile all items removed from dication Room the next day to ars."		Policy No. 8390.11.08 After Hours Dispen. (Attachment F) was updated to reflect the organization's current process and procedures. This was distributed to all staff responsible for dispensing and I medications on 10/18/2018.	-	10/18/2018	
	Dispensing General indicated " If the pharmacy is "close a pharmacist as so preferably within 24 hours following pressure 3. On 7/31/2018 at of the medication in nursing unit 1 (AIP-brown paper bags individually labeled	hospital policy and procedure, al, last reviewed in 4/2018, order is written when the d" it should be reviewed by on thereafter as possible, a hours, but not more than 72 paration and dispensing" 2:45 PM during an inspection from at the Adult Inpatient 1), there were at least seven in a cabinet; each bag was for different patients. Two of		3. Nursing and Outpetient Pharmacy to n October 23, 2018, to address this, and develop a P&P. Inpatient Pharmacy will a and must be involved in the development The agreement mentioned (Attachment J	selst of the P&P.) must be	10/23/2018	
	respectively) were month prior. The la	d for Patient 13 and 14 dated at least ten days to a bels on those brown bags m a pharmacy named hospital.		reviewed and developed into a Policy and both in the Nursing and Pharmacy P&P n			

CENTE	<u>88 FOR MEDICARE</u>	& MEDICAID SERVICES		and the state of t	OMB NO. 0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		054083	B. WING	TOTAL DESIGNATION OF THE PROPERTY OF THE PROPE	08/03/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IULD BE COMPLETION
A 500	Continued From pa	ge 32	Αŧ	500	
	pharmacy (DOP) in discharge medicati pharmacy located v a separate entity (n license). The charge that both patients 1	t interview, the director of idicated those bags contained ons dispensed by a retail within the hospital premises as iot listed on the hospital in nurse in presence confirmed 3 and 14 were still inpatient at d not been discharged.			
,	once discharge pla physician would ord the retall pharmacy dispense and delive charge nurse also le to the discharge pla those medications	PM the charge nurse indicated nning started, the patient's der discharge medications to the retail pharmacy would er to the nursing unit. The indicated if there was a change an, or if the patient declined upon discharge, their tions would be returned to the			
	(CEO) of the hospi retail) pharmacy we hospital had an age pharmacy to disper	PM the chief executive officer tal stated the outpatient (or as not part of the hospital. The reement with the retail use discharge medications for discharge if their patients			
	Discharge Drugs, indicated "The pha to patients upon re physician responsi	oital policy and procedure, ast reviewed on 4/2018, rmacy shall NOT furnish drugs lease from the facility. The ble for the patient shall provide trescription that may be filled at atlent pharmacy."			
	Review of the agre	ement between the hospitel nacy, not dated, indicated if		•	

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

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE BURVEY COMPLETED	
		054083	B. WING	ton substitute and an an annual substitute of the substitute of th	08/03/2018	
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE COMPLETION	
A 500	dispensed by the re discharged, the hos	ige 33 did not receive the discharge stail pharmacy after being spital staff would return the pharmacy within 7 days.	A 50			
	inspection of the homedication storage access, after the plus presence of the directions of the drawers may comedications or medupon admission. In	around 4 p.m. during an espital's night locker (a see designated for after-hour harmacy is closed) in the ector of pharmacy (DOP), wers with signage indicating entained patients' own dication brought from home side one of those drawers, paper bag marked with		4. This will be addressed with Nursing and F Procedure litted "Patients Own Medication".	olicy and	
S.A.	nursing unit, the ch Patient 15 had been Review of the hosp Patients Own Medi- Indicated the nursing	O PM at the Children Inpatient arge nurse confirmed that in discharged on 7/17/2018. Ital policy and procedure, cation, last reviewed in 4/2018, and supervisor would give the patient or their family upon				
A 618	FOOD AND DIETE CFR(s): 482.28 The hospital must is services that are diadequate qualified hospital that has a management comp Condition of Participalitian who serves part-time, or consultations.	nave organized dietary rected and staffed by personnel. However, a contract with an outside food pany may be found to meet this pation if the company has a sine hospital on a full-time, ltant basis, and if the company he minimum standards.	A 61	Corrective action will be accomplished for i dietary service staffing by structuring the didetary service staffing by structuring the didetary service staffing by structuring the didetary service in conditions of the and clinical operations for all listed deficie implement QAPI for Dietary Services in act to 20 - 25 hrs. consultant RD managing Pt and therapeutic care At the present time, it to the current 40 hrs 2 consultant RD, the organization hired. Food service RD for 10 week on consulting basis. (Attachment U)	etary vice stary ncies and idition assessment a addition	

PRINTED: 10/10/2018

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		054083	B. WING	•	08/03/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KEDOEN		AL HEÄLTH CENTER	1	4211 SOUTH AVALON BLVD	
KEDKEN	COMMUNIT MENT	al health center		LOS ANGELES, CA 90011	
(X4) (D PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORREC (GEACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APT DEFICIENCY)	OULD BE COMPLETION
A 618	specified in this sec liaison with the hos recommendations opatient treatment. This CONDITION Based on observat documents, manufinterviews, the hospital was direct qualified personnel of the patients in accorders and accepts (Cross refer A619, A724, A749) 1. Failure to organiservices in a manupatients and appropring appropring the second and nutrition so the meet the educatraining that met st.	ige 34 ction and provides for constant pital medical staff for on dietetic policies affecting is not met as evidenced by: tion, review of facility acturers' instruction and staff pital failed to ensure that the ed and staffed by adequate to meet the nutritional needs coordance with practitioners' able standards of practice. A620, A621, A629, A630, ce the food and nutrition er to meet the needs of the priate to the scope and ervice operations. (Cross refer the provides department who diductional requirements and ate law. (Cross refer A 620) y deficient food safety	A6	dietary service staffing by structuring the department to include:a full time Food of Director RD, will oversee all systems of and clinical operations for all listed defit implement QAPI for Dietary Services. It was consultant RD managing Passessment and therapeutic care At the addition to the current 40 hrs 2 consultant and the current 40 hrs 2 consultant Food service RD for on consulting basis. Restructuring Dieto meet Dietary Department needs of pand keep under the supervision of full to Director RD 3-4. Currently, RD consultant is now a Madical Executive Committee that income Staff, Director of Education and Psy of Nursing, Director of Education and Psy of Nursing, Director of Education and Psy of Nursing, Director of Guality Manage Director of Medical Record Committee basis to review and ensure staff computations are followed and policy and proceed the parameter to include:a full time Food RD, will oversee all systems of dietary operations for all listed deficiencies and constructions for all listed deficiencies and constructions for all listed deficiencies and care and constructions for all listed deficiencies and care an	te dictary Service of dictary clencies and n addition to t to present time, suitant RD, the r 10 hm a week tary Department attents, etary manager 11/15/2018 ime Food Service member of the 09/10/2018 bude Medical Chief chiatry, Director ment and meets on monthly cetancy, QA/GI edures are in pisce. ed for for this 11/15/2018 the dictary Service Director r and clinical d implement
	practices that resul	ited in an immediate jeopardy ifer A 620 and A 749)		QAPI for Dietary Services In addition to consultant RD managing Pt assessmen	

patients. (Cross refer A 621)

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 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.

CENTER	8 FOR MEDICARE	E & MEDICAID SERVICES				<u> </u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	(X9) DATE SURVEY COMPLETED		
		084083	B. WING		08/0	08/03/2018		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE .			
KEDREN	COMMUNITY MENT	al Health Center		4211 BOUTH AVALON BLVD LOS ANGELES, CA. 90011				
(X4) ID PREFIX TAG	BUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREP TAG		HOULD BE	COMPLETION CATE (X8)		
A618	Continued From page 35		A 618 6. Restructuring Distary Department to meet					
	6. Failure to provid	e adequate registered dietitian he needs of the patients.		Oletary Department needs of pallents DIRECTOR.	; Full-time			
	 7. Fallure 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) 			 RD member of the Medical Executo collaborate with nursing and medical necessary to meet patient nutritional 	cal staff as			
				8, 9. Company contracted with a prof		•		
	· · · · · ·	ou fold in outly		menu production Nutricopia to p	rovide, menus ,			
	9. Failure to approve and analyze patient menus. (Cross refer A 629)			nutrition analyzes, recipes. (Atta	chment M)			
	10. Lack of an effe	ctive system to evaluate the		10, 11. New EMR Avatar will be in u	se by all disciplin	ee 1 1/15/2 010		
	nutritional needs o	f patients that includes	that will promote and facilitate the involvement					
	professional stand	ent of patients, current ards.(Cross refer A 630)		of IDT in pt plan of care, ie, s	seasment and p	esment and pt		
	•			follow up. This will incorporat	•			
	assessments acco	orm and document nutrition ording to current standards of fer A621 and A630)		of practice in RD assessmen				
	12. Lack of implementation of a system that ensures the proper food safety practices. (Cross refer A 749)			 Contracted food service RD pu service staff training, to include education, assessing staff con monitoring kitchen operation. 	e training and			
	13. Lack of maintenance of food service equipment. (Cross refer A 724)		13. Maintenance records developed, checked on daily basis.					
	14. Fallure 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)			14. Director of food service RD will activities on daily basis.	l manitor kilchen			
	15. Lack of a data performance impro A 297)	driven quality assurance, overnent program. (Cross refer		15. Online compilance tool implem	nanted for food			

	A MEDIAME DELLA MEDIO		**********		11107 12103	<u> </u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	054083	B. WING			1180	03/2018
ROVIDER OR SUPPLIER		Bearing war	\$T	REET AUDRESS, CITY, STATE, ZIP CODE		
			42	11 SOUTH AVALON BLVD		
COMMUNITY MENTA	al Health Center					
			500		~~~	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE
45. 11. 1			. '			
Continued From pa	ge 36	A 618		ene a company of the part of the company of the com		
				staff provide training, education and should	meet and	t t
nutrition services to direct and staff in such a				ensure that the pt nulritional needs are met	according)
				to standard.		
	od and Dietetic Services was			(1-3)		
		A	319		in in	09/20/2018
CFR(s): 482.28(a)		• • •				
Organization				Director of Food Service in addition to 20		D
Based on observat documents, manufa staff interviews, the food and nutrition s	ion, review of hospital acturers' recommendation and hospital falled to ensure the ervices was organized in a			,		
Findings:						
several deficient pro- could be directly rel organization of the 1. The person in the food and nutrition s not meet the educa- training that met sta 2. Inadequate provi consultation service patients. (cross refi 3. Lack of a system	actices were identified that lated to the function of the department. These include: a position of the director of ervices department who didutional requirements and ate law. (cross refer A 620) sion of dietitian hours and as that meets the needs of the er A 621) to incorporate the services			ensure educational services and training in met the state law. Plan to hire a full time RI Director of Food Service in addition to 20/2 to meet the needs of patients. 2,3. Currently contracted with Food Service ensure educational services and training in met the state law. Plan to hire a full time RI	the Dept Das 5 hrs RD RD to the Dept Das	08/20/2018 08/20/2018
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI Continued From pa The cumulative efferesulted in the inable nutrition services to manner to ensure the patients were met in practitioners' orders professional practic Participation for Formot met. ORGANIZATION CFR(s): 482.28(a) Organization This STANDARD is Based on observate documents, manufact staff interviews, the food and nutrition is manner to meet the findings: During the survey for several deficient procuid be directly reforganization of the 1. The person in the food and nutrition is not meet the educate training that met site 2. Inadequate provice patients, (cross reference and expertise of a reformal control of a reference and expertise of a reference control of a system and expertise of a reference control of a system and expertise of a reference control of a system and expertise of a reference control of a reference control of a system and expertise of a reference control of the control of th	COMMUNITY MENTAL HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 clid 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)	PROVIDER OR SUPPLIER COMMUNITY MENTAL HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 Perticipation for Food and Dietetic Services was not met. 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 falled to ensure the food and nutrition services was organized in a manner to meet the needs of the patients. 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Lack of a system to incorporate the services and expertise of a registered dietitian in the	PROVIDER OR SUPPLIER COMMUNITY MENTAL HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 Continued From page 36 A 618 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. 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 diatitian in the	OF DEPICIENCIES F CORRECTION OS4083 ROVIDER OR SUPPLIER COMMUNITY MENTAL HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY SHATE SEPECIENCES) (SACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 proclitioners' orders and acceptable standards of professional practice. Therefore, the Condition of Participation for Food and Dietetic Services was not met. ORGANIZATION 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 621) 2. Inadequate provision of dietitian hours and consultation services that meets 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 dietitian hours and consultation services that meets 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 director of food and nutrition services department who did not meet the educational requirements and training that met state law, (cross refer A 621) 3. Lack of a system to incorporate the services and expertise of a registered dietitian in the	OF DEPICIENCIES FORRECTION (X1) PROVIDER DESTIFICATION NUMBER: 054083 8. WING ROVIDER OR SUPPLIER COMMUNITY MENTAL HEALTH CENTER CONTINUED FOR USE OF SENTEPHING HE ORBANTON) 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. ORGANIZATION CFK(s): 492.28(a) Crganization This STANDARD is not met as evidenced by: Based on observation, review of hospital felded to ensure the cod 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 department who did not meet the educational requirements and training that met state law. (cross refer A 620) 2. Insidequate provision of dietitian hours and consultation services that meets the needs of the elients, (cross refer A 620) 2. Insidequate provision of dietitian hours and consultation services that meets the needs of the elients, (cross refer A 620) 2. Insidequate provision of dietitian hours and consultation services that meets the needs of the elients, (cross refer A 620) 3. Lack of a system to incorporate the services and expertises of a registered dietitian in the

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	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-03					
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	:	054083	B. WING			08/03/2018		
	PROVIDER OR SUPPLIER N COMMUNITY MENTA	AL HEALTH CENTER		421	EET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTH AVALON BLVD			
(X4) ID PREFIX TAG	(Each Deficiency	tement of deficiencies / Must be preceded by full sc identifying information)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) be completion		
A618	of the patients. (Cro 5. Lack of an effect nutritional needs of follow-up assessme professional standa 6. Lack of impleme ensures the proper refer A 749) 7. Lack of maintena equipment. 8. Lack of a data di performance impro According to the re hospital's director of hired seven month August 1, 2018 sta explained that he h experience and no required by state is did not manage the	at meets the nutritional needs use refer A 629) live system to evaluate the patients that includes ent of patients, current ards, nutation of a system that food safety practices. (cross ence of food service enternation of a system that food safety practices, cross ence of food service enternation of the of food services (DFS) was a searlier. In an interview on riting at 4:00 PM, the DFS ad been hired based on his ton the education experience w. He further explained that he eday-to-day operation of the		; 319	(4-8) 4. Contracted with Professional RD vendor Nutricopia (Attachment M) to provide mer company Full time RD , Director of food s monitor food service personals, day to da develop quality assurance program (QAP Addressed in detail in staffing A618	nu for ervice to y ectivities and		
A Company of the Comp	functions of the de- ordering, attending The DFS had not of course for manage food service worke course (food hand)	ponsible for the administrative partment including food meetings and doing payroll, ompleted the food safety rs. He did not ensure that all rs completed food safety ers) required by state law.	•					
	current food safety "Receiving Food at under the subhead food, leftover food produced food whit table, may be store	rocedure manual did not reflect practices. The policy titled, and Supplies" dated 4/26/17 ling "Handling over-produced and extra food" states "over the has not been on the steam of for later use. The food int saved food and failed to food.		:	RD, Director of Food Service oversight on staff training sessions were conducted reg and extra foods , pre and post lest results compliance Online folder. Training was co 8/3/2018 at 2:00 p.m. (Attachment N).	arding isftover avallable in		

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O		0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
**************************************		054083	B. WING	***************************************		08/0	3/2018
NAME OF I	PROVIDER OR SUPPLIER			i	REET ADDRESS, CITY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER .	**************************************	1	11 SOUTH AVALON BLVD DS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X8) COMPLETION DATE
A 619	Continued From pa	ge 38	A	619			
	dietitians (RD) to prepatients and limited The RDs were not a patient care service RDs were schedule hours was from 4:1 most of the patients healthcare provider are not available. Thursday, Saturday "stat" order for a nu on one of the days, (not scheduled) in the consult was not cororders are orders the urgency. The RD 2 2018 starting 9:12 assessment the new Patient 40 who los was transferred out a result of the weight.	red two part-time registered covide nutrition care to the food service responsibilities, always available to provide es. The hours the one of the ed were not customary. RD 1's 5 AM to 10 AM. At this time, is are asieep and most other s, the interdisciplinary team there is no RD scheduled on and Sunday. There was a strition consult for Patient 40 the RDs were not present the hospital. The nutrition in an interview on August 3, AM stated she completed the ext day, this happened after to the acute care hospital as the loss and refusal to eat.		,			
.t	addressed when fo conducted on patie admitted for over se reassessed. RD 1 a August 3, 2018 ack policy and procedureassessment of pademonstrated probobservation on August 3 assessed Patient 3				New EMR charting program will ensure the assessment and follow up are documented policy and procedures of the Department.		

One of the responsibilities of the RDs is the

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA	(X2) MU	LTIPLI	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION .	IDENTIFICATION NUMBER:	A. BUILD		·	COM			
		054083	B. WING			08/	03/2018		
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			rreet address, City, State, Zip Co				
KEDREN	COMMUNITY MENT	AL HEALTH CENTER			111 SOUTH AVALON BLVD OS ANGELES, CA 90011				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	IX.	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	8HOULD BE	(X6). COMPLETION DATE		
A619	taws. The menus v that it was adequat daily values for the The kitchen and co recipes to prepare	age 39 nus under federal and State vere not analyzed to ensure to meet the recommended population served. book were not provided with dishes to ensure consistency The food service workers	A	619	Menue will provided by a contracted Nutricopia , including nutrition analy production manual. Contracted Foo currently training food service empl implementations. (Attachment N).	vals, recipes , ed Service RD is			
A 620	The food and nutri its services to impr	Ided with aprons to help protect the from cross contamination. tion services did not evaluate ove services provided. ETARY SERVICES (1)		620	· .				
	The hospital must	have a full-time employee who-							
	(i) Serves as dire services;	ector of the food and dietetic							
	(ii) la responsible dietary services; a	for daily management of the nd							
	(ili) is qualified by	experience or training.		•			•		
	Based on observed documents, manustraff interviews, the director of food an necessary training to manage the ser and complexity of deficient practice is anitation practice.	is not met as evidenced by: titon, review of hospital facturers' recommendation and a hospital failed to ensure the d dietetic services had the , experience and qualifications vice appropriate to the scope the service operations. This esuited in poor food safety and s that resulted in immediate							
	jeopardy situation 2018. The director	being declared on August 2, of food service did not:					•		

CENTER	<u>KS FOR MEDICARE</u>	& MEDICAID SERVICES			6	MB NO	<u> 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETEO
		054083	B. WING			08/	03/2018
NAME OF F	PROVIDER OR SUPPLIER	4	2017/114 015/11/11/11/11/11	\$	STREET ADDRESS, CITY, STATE, ZIP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
KEDREN	COMMUNITY MENT	AL HEALTH CENTER		'	1211 SOUTH AVALON BLVD LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		Provider's Plan of Correction (Each Corrective Action Should Cross-Referenced to the Appropr Deficiency)	BE	(X5) COMPLETION DATE
A 620	including proper co food labeling. 2. Ensure that food good working order 3. Ensure that staff perform food service food thermometers 4. Ensure that the re the hand washing a washing. 5. Ensure the hand sink was installed i cross-contamination Findings: A review of person DFS did not have a required by state la Safety Code 1265. health facility (hosp time registered die dietary services su educational require	actices for food handling of down, proper storage and service equipment was in the description of the educational training aw. California Health and 4 requires that a licensed of the provisor who meets some sements. The requirements	A	320		Food	09/14/2018
	with major studies or food manageme in a licensed health dietetic technician the (3) a gradi	n)(1) a baccalaureate degree in food and nutrition, dietetics ent and one year of experience in facility (2) a graduate of a training program approved by uate of a dietetic assistant pproved (4) a graduate of a			i		
	dietetic services to the Dietary manag certified dietary ma Certifying Board of Association, maint	phroved (4) a graduate of a alining program approved by ere Association and is a anager credentialed by the if the Dietary Managers ains Certification (5) a ge degree with major studies in	:			>	

CENTER	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		054083	B. WING		08/03/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Y Must be preceded by full SC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOL CROSS-REPERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A 620	food and nutrition, cullnary arts, or hot certified dietary me state approved prohours of classroom supervision (7) I	ge 41 dietetics, food management, el management and is a anagement and is a graduate of a gram that provides 90 or more instruction in dietetic service Received training experience arvision in the military"	A 6:	20 RD consultant, food service, providing in to dietary staff followed by competency evilated on August 20, 2018.	
	he did not have any training and or expe interview on August he was hired based	od Service (DFS) stated that of the outlined educational erience. He stated in an an act 2018 starting at 4:00 PM, I on his decades of experience industry not on educational			
	AM, there were sev were leftover food if the second shelf. If cooked rice dated is labeled 7/30. There dated 7/29, a conta 7/26. There was als	efrigerator on July 31 at 11:45 reral containers of food that from previous meals stored on here was a container of 730, a container of ham also was gravy in a container iner labeled meatballs dated so a large 6- quart container e filled almost to the brim.			
*	lower shelf in the re	box of peas stored on the frigerator with manufacturer's p frozen until ready to Cook*.		Tools, logs have been created to monite activities RD consultant for food service offer training class on areas of deficiency	continue to
	AM. A request for c evaluate whether th appropriately, DFS 31, 2018 at 11:48 A	is shared with DFS at 11:48 coling logs was made to re items were cooled stated in the interview on July M, there were no cooling logs al not save leftover items.			,
	On August 1, 2018 leftover items obse	at 10: 25 AM, there were wed stored on the top shelf in		:	

		& MEDICAID SEKVICES				ONB NO. 0938-039
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING	**************************************	Managara a a a a a a a a a a a a a a a a a	08/03/2018
NAME OF	PROVIDER OR BUPPLIER		and the second	STREE	TADDRESS, CITY, STATE, ZIP CODE	
				4211 8	OUTH AVALON BLVD	
KEDREN	I COMMUNITY MENTA	AL HEALTH CENTER			INGELES, CA 90011	
	A			MOO!	**************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full BC identifying information)	IO PREF TAG)X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	NTD BE COMPLEMO
A 820	the refrigerator. The dated 7/26/18, dice dated 7/23/18, red pated 7/29/18 anot 7/30, garlic potatoe believed there was leftover items and tings. Cook 1 stated fack of monitoring of the observation was DFS stated on Augkitchen's priority was	are was sally mashed potato d potato dated 7/12/18, beans potatoes dated 7/12/18, rice her container of rice dated s 7/26. Cook 1 stated he a 3- day grace period to use hey do not monitor or use any he had not considered the	A	state	sultant food service RD is addressin ad in- services in progress by food s sultant.	•
	cooling of food, lack system to impleme corrective action or had been identified immediate jeopardy potential to result in was removed (abat PM.	ospital to monitor proper k of staff knowledge and the lack of the process and the lack of the part of the DFS after it the day before created an (IJ) situation that had the food borne illness, The IJ ed) on August 3, 2018 at 3:05 the kitchen on July 31, 2018		W a any	and the second s	7/2016 08/27/201
	starting at 11:10 AN surveyor found the uncomfortably warry warning of the high 1, 2018 at 10:20 Af water temperature warm. In an interviewarm, in an interviewarm, DFS temperature, DFS the water temperature acknowledged the allow food service to the water temperature.	I, during hand washing, the water temperature to be in. There was no signage water temperature. On August I during hand washing, the once again felt uncomfortably with the DFS on August 1, about the high water stated he was not aware that	,	Logs	parature gauge was replaced on 8/2 s are checked daily. Paper work at n ineering Dept. (Atlachment P).	112010.

- 101 T T 101	10 1 01 1 11 11 11 11 11 11	MINIMINIALIN APILIAPA	(charles chimales become	alada a sanana a sanana		WILLY IV	0. V200-V00 I	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X8) D/	(X8) DATE SURVEY COMPLETED	
	•	054083	B. WING		ald talentalish reterm i de sleiske heli ele (4) de john met morte mort gem sit elektrikken.	0	8/03/2018	
	ROVIDER OR SUPPLIER COMMUNITY MENT	al Health Center		421	EET ADDRESS, GITY, STATE, ZIP CODE I SOUTH AVALON BLVD 3 ANGELES, CA 90011		*	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X8) COMPLETION DATE	
A 620	requested that wat	age 43 egistered dietitians (RD 1) had er temperature be increased d up by the facilities	A	320		,	,	
·	126.1 degrees Fah more effective than fatty soils encounte flow of warm water aid in flushing soil of water temperature	ck of the water showed it as renheit (F). Warm water is cold water in removing the pred in kitchens. An adequate will cause soap to lather and quickly from the hands. High that makes hand washing y lead to poor handwashing mployees.		Т	emperature gauge was replaced on 8/2	7/2018.	08/27/2018	
	5-202.12 (A) "A hat equipped to provid least 100 degrees combination fauce the efficacy of han a water temperature. Society for Testing international standards for a wide systems, and servit Also attached to the station. Higher wat the eyes and can ewith the skin and ewashing sink was I from the drain boar There was no splat contamination of don to food that may preparation sink.	e faucet was an eye wash er temperatures are harmful to enhance chemical interaction yes. In addition, the hand ocated less than six inches ed of the food preparation sink, sh- guard preventing cross lity soapy water from splashing y be prepared on the		(facility work order was placed to remove vash fixture and replace with regular faulxture to provide a constant water low for hand washing to be in compliant Attachment Q).	cet	08/20/2018	
	In the spice cabine	t in the kitchen, there was an						

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		(III)		QMI	B NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(a) DATE SURVEY COMPLETED
	Windows In the International Control of the I	054083	B. WING	lki iki liki kanga ing kanga i	en a mentale de la company		08/03/2018
NAME OF I	PROVIDER OR SUPPLIER	7,7		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENT	al Health Center			SOUTH AVALON BLVD SANGELES, CA 80011		
(X4) ID	ATO VOSMINIS	TEMENT OF DEFICIENCIES				************	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	E COMPLETION THE DATE
A 620	"6/8/18". Manufactu "Refrigerate after o	ge 44 container of BBQ sauce dated irer's recommendation stated pening". The food service uring the observation, stated	A6	20			۳
	on July 31, 2018 at that the sauce requindicated that the di date received. FSV date items were op- instructed by RD 1	11:19 am, she was not aware fred refrigeration. FSM ate on the containers is the V stated that they do not put ened because they had been to only put date the item was re items such as spices, not					
	were other items in dates and not dated FSM who was pres stated the errors manufactures in employees that were	istent labeling system. There the kitchen that had expiration if when they were received, ent during the observation ay be due to new and agency re recently hired who may and labeling differently.					
	all the way to the rocclearance. The foor to the fan on the co- tightly packed that reduced. In an con-	reezer, there were item stored of of the freezer with very little ditems were stored very close indenser. The items were very coor air circulation was current interview observation 3 PM, DFS indicated that the limited.	·	· · · · · · · · · · · · · · · · · · ·			
	measuring cup was container of flour. T	31, 2018, a large plastic sobserved stored in a storage the FSM who was present lion removed the cup.					,
	2-compartment sini	iance uly 31, 2018, the faucet in the k was leaking hot water in the nent water. The constant	•				,

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		054083	B. WING		and the state of t	0(3/03/2018	
	PROVIDER OR SUPPLIER COMMUNITY MENTA	al Health Center		421	reet address, city, state. ZIP code 11 South Avalon BLVD 08 Angeles, ca 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	obe	(X8) COMPLETION DATE	
A 620	Continued From pa dripping of the hot potential to dilute the making it ineffective	water into the solution had the ne concentration, thereby	Α	620		*	:	
	machine was broke at 140 degrees F for cycles. Food service operated the mach temperature of machand-held food the are recorded while different cycles. The observation that sillong the thermometer in the temperatures. The gauge with her fing thermometer from temperature gauge wash cycles were unsafe due an inci-	temperature gauge for the dish an and temperature was stuck or both the wash and rinse be worker (FSW 3) who interested the water chine is checked using a rmometer. The temperatures watching and listening to the se FSM stated in a concurrent se could not remember how ster had broken and when the started inserting a food a water well to check water FSM flicked the temperature yer, which moved the 140 to 130 degrees F. The edid not move after several observed. The process was reased the risk of burn as the it was flowing and circulating	•		Temperalura gauge was replaced on 6/27/	2018.	08/27/2018	
	facility) Dishwashe month July 2018 h F for the wash cyc breakfast, 25 of 3 days for dinner. For temperature of 14	pital document titled "(name of or Temperature Log" for the ad a recording of 130 degrees le (28 out of 31 days) for I days for lunch and 27 of 31 or the final rinse cycle 0 degrees (F) was recorded 29 breakfast, 29 out of 31 days for days for dinner.						
	4-602,11 (C) "Aml	017 Food Code Section lient air temperature, water or temperature measuring		i	;		ŧ	

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	4			FOR	D: 10/10/2018 M APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŧ .		E CONSTRUCTION	(X3) DA	TE SURVEY OMPLETED
		054083	8. WING	3 <u></u>	SANAN SA	l n	3/03/2018
NAME OF I	PROVIDER OR SUPPLIER		I	81	TREET ADDRESS, CITY, STATE, ZIP CODE	.1	J/V0/2010
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		ŧ	211 South Avalon Blyd Os angeles, ca 90011		the state of the s
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 620	Continued From pa	ge 46	Αŧ	620			
	devices shall be ma accurate within the	intained in good repair and be intended range of use."			•		•
	3. There was water faucet in the chemic outside the kitchen. two paired hose bib red and black in col "threaded faucet als The end of the red ton the floor with a d bubbles resembling connection did not back-flow prevention significant build- up on the rack adjacen rust. There was a sithe horizontal brack keep the faucet in p	spewing out leaking from the cal storage/janitorial area Attached to the faucet was a connection, the hoses were or. A hose bib(b) is a so known as a wall hydrant". Hose was inside a blue bucket ark brown solution, with soap or detergent. The nave an anti-siphon or in device. There was a of a brown colored substance to the faucet, resembling milar colored substance on et that held the water pipe to lace. The presence of rust on of the presence continued			3. Facility work order was submitted to repleaking faucet. (Attachment Q)	alr.	08/01/2018
3	5-203.14. "a plumbi preclude backflow contaminant into the point of use at the fron a hose bibb if a hackflow prevention providing an air gap	17 Food Code Section ng system shall be installed to of a solid, liquid, or gas a water supply system at each cod establishment, including nose is attached and of its required by law, by: (a) of as specified under § alling an approved backflow ."					
,	2018 at 3:30 PM inc the leaking of the fa FSD on August 1, 2 FSD indicated he m	or in an interview on August 1, dicated he was not aware of ucet. In an interview with the 018 starting at 4: 00 PM, the lade reports to the facilities ne various equipment that		4.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X8) DATE SURVEY COMPLETED		
		084083	B. WING	j 		08/03/2018		
	ROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER		4211	EET ADDRESS, CITY, STATE, ZIP COD SOUTH AVALON BLVD B ANGELES, CA 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- GROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X8) COMPLETION DATE	
A 620	needed repairs. Ti	age 47 ne FSD stated the reports were it was unable to provide ports because he "does not	A	620				
	service worker (FS recipes. Cook 2 processor of the co	vations with Cook 2 and Food (SW) 1 preparing food without repared Cheese Enchilada a recipe. FSW 1 was observed gust 1, 2018 preparing fruit cipe. The lack of recipes was a FSW on July 31, 2018 at 1:40 he interview stated that there is from the new menu cycle but at have a complete set of its prepared. The DFS stated in ugust 1, 2018 starting at 4:00 was responsible for the kitchen heible for administration.						
and the second s	through August 3, were observed we food service dutie including those pr	ns in the kitchen from July 31 2018, only three employees earing aprons as they performed s. Other food service workers eparing food and helping with leals did not wear aprons.			Hospital contracted with a new comp Uniform, to provide these services.	pany, Republic	01/01/2016	
	workers on Augus FSW explained th them with uniform they need aprons aprons themselve stated in an interv PM, that he purch takes it home to le	th the group of food service at 3, 2018 at 2:55 PM, a random at the hospital does not provide is and the expectation is that if they will have to purchase the is. FSW 3 who had an apron iew on August 1, 2018 at 2:15 ased the apron he had and aunder. Cook 2 who was also stated in an interview on Augus						

	<u> 10 l'OU MEDICAUE</u>	& MEDICAID SERVICES				UIVID N	<u>U. 0830-038 </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) C	OATE SURVEY OMPLETED
		054083	B. WING		THE THE PROPERTY AND ASSESSMENT OF THE PROPERTY ASSESSMENT ASSESSM	0	8/03/2018
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
VENDEN	COMMUNITY MENTA	N LICATEL ACRES		4211	SOUTH AVALON BLVD		1
111mm Trick	Activition of the control of the con	al Health Center		LOS	ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Y must be preceded by full SC identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 620	provide him with the plastic apron melt vistove and heating of present during the lives "between vend being provided with A review of the contractor 1, (kitchen towels, aprovider) did not incorprovided. There was contract but no aprovided. In an intervision (LS) on LS acknowledged I not provide aprone	M, that the hospital did not a apron. Cook 2 stated that the when he gets close to the equipment. The FSM who was interview stated the hospital fors" and are currently not aprons. It acts between the previous reservices provider, indicated previous provider) provided cons, chef's coat, cook shirts of the service (Exhibit B). A act for Contractor 2, (current dicate if similar items were as a list of items as part of the cons or kitchen towels were on lew with the Laundry August 3, 2018 at 3:00 PM, that the laundry services did	A	320			
	the patients to posi- food from clothing, diseases that are to Food employees w dirty clothing may o could result in cont prepared. Food ma through direct cont Code Annex) According to the 2	for food service staff exposed sible cross contamination of Dirty clothing may harbor ransmissible through food, he inadvertently touch their contaminate their hands. This amination of the food being ay also be contaminated act with dirty clothing. (Food 017 Food Code Annex "All of ol measures should be					
- Andrews	implemented regar process used: cross-contamination	dless of the food preparation	•	•			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	•	054083	B. WING			08/03/2018	
KEDREN		AL HEALTH CENTER		5 4	TREET ADDRESS, CITY, STATE, ZIP CODE 211 SOUTH AVALON BLVD OS ANGELES, CA 90011 PROVIDER'S PLAN OF CORRECTIO		
(X4) ID PREFIX TAG	(BACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	IN (X6) DIBE COMPLETION PRIATE DATE	
A 620 A 621	animal foods.	nsils, aprons, etc., or raw		820 821	Contracted with Professional RD vendor Nutricopia (Attachment M) to provide menu organization, Full time RD, and Director of	for narrows	
	CFR(s): 482.28(a)	(2) ualified dietitlan, full-time,		· · · · · ·	Service to monitor food service personnels activities and develop quality assurance pro (CAPI) Addressed in detail in staffing A618	day to day ogram	
	Based on observation documents, clinical interviews, the hos	is not met as evidenced by: tions, review of hospital il record review and staff spital failed to ensure that the			New EMR will facilitate , and the available information to all involved will improve assessments and plan of care		
	contracted register supervised the nut. The frequency of contritional needs of delitians failed to: 1. Approve and an 2. Perform and do according to curre 3. Collaborate with services to plan an necessary to meet patients.	red dietitians adequately ritional aspects of patient care. consultations did not meet the f the patients when registered alyze patient menus. cument nutrition assessments nt standards of practice. In nursing services and other ad implement patient care as it the nutritional needs of the ht of the food service operation.			3-7. Contracted with Professional RD vend Nutricopia (Attachment M) to provide ment company Full time RD , Director of food se monitor food service personnel, day to day activities and develop quality assurance pr (QAPI) Addressed in detail in staffing A616	for rvice to ogram	
	and its director of state educational 5. Identify deficien resulted in an imm 6. Provide adequa of the patients.	food services who did not meet requirements for the position. It food safety practices that nedlate jeopardy situation. It coverage to meet the needs ty assurance performance			· .		
	Findings:						
		cts showed that the hospital contracts with two dietitians (RD	•			t	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

John M. Lond	20 LOIZ MEDIONICE	WINEDICAID SEKAICES	·			CIMB 147	1. 0930-039 L
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		054083	B. WINC) ************************************		00	3/03/2018
	PROVIDER OR SUPPLIER I COMMUNITY MENTA	AL HEALTH CENTER		4211	eet Address, City, State, Zip Code I South Avalon BLVD 3 Angeles, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETION DATE
A 621	dietary and nutrition stipulations on the	ge 50 vide services "in the field of hal services". According to contracts, both RD 1 and RD 2 h not exceed 20 hours per	A	621			
	starting at 9:00 am, hours are from 4:19 week, RD 1 explair days a week, Both (Mondays and Frid overlap, RD 1 also RD 2 works on Tue	RD 1 on August 1, 2018 RD 1 indicated her work 5 am to 10:30 am, three days a 1ed that RD 2 also works three RDs work the same two days 1eys) but their hours do not 1eys works on Wednesdays, while 1esdays. There is no RD 1eys and weekends.					,
	1 indicated that in a responsibilities, sho and audit of the kits does in service edu related to the manu same interview tha mainly for "patient	n RD 1 on August 1, 2018, RD addition to clinical nutrition be does a monthly inspection chen. RD 1 indicated that she ucation of the kitchen staff u. RD 1 further stated in the t the hospital hired the RDs care" and have no oversight of the service responsibilities.		•			
	at 9:12 am, RD 2 s	ID 2 on August 3, 2018 starting tated the hospital had limited as to no more than 80 hours a uld not exceed the hours.		;			
	write or prepare a regulatory requirer both regular and the registered dietitian either RD 1 or RD	atory requirements for who can menu. However, there are nents for menu approval of terapeutic diets by the . There was no notation that 2 approved the menu. A yeek hospital menu showed the		; ;			

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STATEMENT AND PLAN O	of Deficiencies F Correction	(X1) PROVIDER/BUPPLIER/GLIA (DENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		054083	B. WING			08/0	3/2018	
NAME OF	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE			
				42	211 BOUTH AVALON BLVD			
Kedren 	COMMUNITY MENT	AL HEALTH CENTER		U	OS ANGELES, CA 80011			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREP TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL GROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON JD BE PRIATE	DATE COMPLESION (X2)	
A 621	names of the two of different weeks of of printed on two of the menu. The name of the menu signifies deemed appropriate content, texture, perpropriate ness, dof the patients among the menu signifies of the patients among t	ifferent RDs who prepared the menu. RD 2's name was se weeks as preparing the of another RD (RD 3) was the menus. The approval of that it has been reviewed and te in terms of the nutrient opulation, cultural isease and specialized needs ong other criteria, by the tho is knowledgeable about the	A	621	New menu provided by Nutricopia Menu t are in place. RD consultants will address menu, training, and implementation. Nutri menu will provide daily production menus recipes, weekly purchasing guides, multiti therapeutic diets, manu approval form for updates to maintain current regulatory an atandards of practice. Contract signed on	the new copia , standardize onal analysis RD, system d accepted		
	starting at 9: 30 an weeks of the ment that her name prin she had approved present during the unable to explain a approved menus if	Interview on August 3, 2018 in that she updated two of the is. She stated she had believed ted on the menu implied that the menu. RD 1 who was interview and RD 2 were and demonstrate how they if the name on the menu was (RD 3) who according to RD 2 for the hospital.	ţ		New menus include the recipes required. I start date 01/01/2019.	Production	01/01/2019	
	August 1, 2018, for observed preparing recipes. RD 2 in the she had provided to she had written. So nor RD 1 ensured recipes to prepare menu. RD 2 states analyzed to evalue and validate that it needs of the patie hospital did not hat	tervations on July 31 and od service workers were g different entrée items without le same interview stated that recipes for menu for the weeks he acknowledged neither she that the food service staff had all items on the five week cycle it the menu had not been ate the adequacy of nutrients would meet the nutritional int population because the we the computer program that . (Cross refer A828)						

		A MEDICAID SEKVICES	yy	**********	<u> </u>	AIR MA	. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		٠.
RGUDEN	MARKETTAL BARRETT	AL LICALTH MENTER		4	211 SOUTH AVALON BLVD		
NEDICEN	COMMUNITY MENTA	AL DEALIN CEALER		L	OS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
A 621	was admitted to the diagnoses of diabet diagnoses. Diabete the body does not presulting in high bid ordered diet was 20 diabetic diet. The A Association) diet is statement in 2002, the term "ADA diet" ADA no longer end	atient 39 showed Patient 39 thospital with medical tes in addition to psychiatric is a medical condition in which produce enough insulin tood sugar. The physician 200 Cal (calorie) ADA diet-DA (American Diabetic an outdated diet. In a position the ADA "recommended that orses any single meal plan or ges of macronutrients as it has	, At	321	New EMR will facilitate, and the availability information to all involved will improve asse and plan of care. New menus include the rerequired. Production start date 01/01/2019.	sements	01/01/2019
	was 1800 Cal ADA the menu. RD 2 in 3, 2018 starting at were served because by the physician". In either provided trace stated that the physician the fact that the AD of the facility diet must be medical Director 11:35 AM, the MD aware that the ADA	8 menu showed that there and 2000 Cal ADA diets on the same Interview of August 9:12 AM stated that the diets see that was what "was ordered RD 1 and RD 2 acknowledged aining to the medical staff. RD hysicians were not educated on the Adet was outdated. A review nanual showed that the diet drate diet. In an interview with or (MD) on August 3, 2018 at indicated that he had not been a diet was outdated and that he had not order such diets had about it.		,	Incorporate current standards of practice in assessment. RD will evaluate pt tolerance therapeutic diets when appropriate.		08/20/2018
	and used to development and used to development and used to develop the medical nutrition nutr	ents nformation nutrition gathered p nutrition assessments and nerapy was not adequate to the xity of the population served.		,			· ·

STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
•		054083	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	08/03/201B
	ROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (BACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILO BE COMPLÉTION
A 621	height, weight, esti and a plan which v "provided basic nu In an interview with	te RDs included type of diet, imated caloric needs per day was mostly checked off as tritional services".	A 621		
	are assessed within provided a docume intake Pattern Callindicated was used of patients. The chased on sex, againto consideration	n, RD 1 stated that all patients in 72 hours of admission. RD 1 ent titled "MyPyramid Food orie Levels" which RD 1 d in estimating nutrition needs eart which assigns calorie level and activity level does not take height, weight, overweight or mination, protein and fluid			. :
	Association) Core of Practice Indicate Indicators to evaluand correlate one advanced clinical hollstic focus of becomplex disorder) Nutrition and Diete Association) RDs to be familiar with	008 ADA (American Dietetic Registered Dietltian Standards ors, the RD in Behavloral health e detailed analysis of the ate the complexity of problems problem to another (i.e. using judgement skills reflecting the chavior health care as a . According to Academy of atics (formerly American Dietetic in behavloral Health are urged the Standard of Practice and seional Performance in Care.	· . •	Full time Food Service Offictor to impler chart review EMR will address deficiency	
	chart was used to all the patients. The is to evaluate cate Academy of Nutril "the Mifflin-St Jec	nical records showed that this determine the caloric needs of he current standard of practice hic, protein and fluid needs. The ion and Dietetics (2017) states r equation is the most accurate or estimating nutrient needs) for		, ;	; · · · · · · · · · · · · · · · · · · ·

		A MEDICAID SERVICES	-			AD NO.	0838-0381
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	i	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		054083	B. WING			08/0	3/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	Œ	······································	
KEDREN	COMMUNITY MENT	Al MGALTH CONTED		4211 SOUTH AVALON BLVD			:
e ymosef I hii l 1		am timemiti messieu		Los angeles, ca 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD	BE	(X5) COMPLETION DATE
A 621	Continued From pa	an EA	A e	, ona	,		
rs Val			AE	921 -			
	kilogram body weig	individuals", 0.8 gm per tht is the calculation for protein					
		ters (a measure of volume) x			•		
		ht is the calculation for fluid					
	needs.						
	In the base of the second	. Men na mana industrial and a second		•			
		RD 2 and RD 1 on August 3, 2 AM, RD 2 stated that she					
:		z Alvi, KD z stateu triat and Ion assessments done with					i
		ries, protein and fluid and					
		sultant practice in another level		•		-	
		y have never done so at this					
		1 who was present during		,			,
:		D 2 provided any rationale as				-	
		mplemented the current assessment calculations and					
	formula at the hosp						
·	•					•	•
		sing initial assessment form		RDs will sitend Nurses monthly meeti	na ta av	channa	
	nad an incomplete	information on screening nat risk. There were a set of			ing its us	res testifie	
		gned points. The form is titled		information.			
		Nursing History and					
	Assessment -AIP"	dated 11/2015. However, there		·			
		on what those points indicated		•			
		needed to do if any of the					
		d. In an interview with the two NN1 and CN N1) on the adult					
		gust 2, 2018 at 11:30 AM, both					
		ot understand the section on					
	the form and did no	ot routinely complete the		•			
·	section. The Chief	Nursing Officer (CNO) in an		;			•
		1 2, 2018 at 1:37 PM stated					
	tnere were no polic Nutritional Screenir	ies that explained the	É	1			
	LANGUMUN DOLGOITH	ig awiiiig hiddaa.		i			
	RD 1 stated in the	August 3, 2018 Interview that					
	the form was revise	ed about a year or so ago but	•	1 j			
	the instructions we	re omitted in the latest			•		

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
STATEMENT	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WING			90	3/03/2018
	ROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER		4211	eet address, city, state, zip code I South Avalon BLVD 3 Angeles, ca 80011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full .sc identifying information)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
A 621	revision. A review revision. A review "RNs Mental Health Assessment -AIP" subheading "Nutrit eleven different or with nine of them. points and instructional points and instructional feet of the asthe screening was health population "Assessment of E Acute Mental Illne Developmental and Practice Group of Association, lists a questions approprincluded assessment decreased aware about food, Eating large for safe swademanding behave the assessment for	of the hospital document titled th Nursing History and dated "7/2004" under the iteria with points associated There was an area for total iteria with points associated There was an area for total iteria with points associated There was an area for total iteria with a score of three is consult is needed within 24 sessment questions indicated at not tailored to the mental served. A 2006 document titled ating Behaviors for patients with ass" by The Dietetics in iterial properties and assessment tate for this group. The lists ent of cognitive behaviors such a served are so of need to eat, paranoic Behaviors such as bites too likew, social behavior such as iter in the dining room as part of or the population served. These ame behaviors documented in	· · · · · · · · · · · · · · · · · · ·	621			
	including schizopi food was being preat. The physicial regular diet and natimes a day. Nurs 40 consuming me admission throughtransferred to the	other services admitted with diagnoses irrenia. Patient 40 belleved his cisoned and so he refused to n's order for Patient 40 was a utritional supplements three ing staff did not observe Patient hals from 7/12/18, date of h 7/28/18 when he was acute care hospital. Patient 40 mai supplements from 7/12/18	. , , , , , , , , , , , , , , , , , , ,		1. RDs will attend Nurses monthly meeti exchange information.	ngs to	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0					
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		DATE SURVEY COMPLETED	
		054083	B. WING			1 (08/03/2018	
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		4211	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVALON BLVD B ANGELES, CA 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XE) COMPLETION DATE	
A 621	admission, lost 11 p was transferred to a rehydration.	ge 56 lent 40 weighed 138 lbs. on lounds in 14 days before he an acute care hospital for lew of Patient 40 indicated the	A	321				
	RD completed a nu of admission. The fassessments or do continued to refuse Nursing notes indic provide meals in se Patient 40 that mea an interview with L1 12:30 PM, LN N1 ir offered "cup of noo prepared by adding The container had item and may have did not consume it.	trition assessment on the day RD did not complete any other cumentation when Patient 40 meals and lost 11 pounds. ated that nurses attempted to aled containers to reassure als were not tampered with. In N1 on August 2, 2018 at adicated Patient 40 was die". The noodle dish is water to dehydrated noodle, to be opened to prepare the contributed to why Patient 40 Other prepackaged products	,					
	been offered to Pat been opened to pre Foodservice managed: 25 PM stated that products that they cauch as those on K	frozen dinners, could have ient 40 that would have not pare and serve. The per (FSM) on August 2, 208 at it they have prepackaged occasionally obtain for patients osher diets that would have or Patient 40 had the RD					.•	
1	2, 2018 at 12:40 Pl Patient 40 to the Ri Interview that it was protocol to call the they (nursing staff) Interview on Augus stated that she was	ed in the interview on August If the nursing staff did not refer Ds. LN N1 stated in the same In not part of the hospital RO if a patient does not eat, call the physician. RD 2 in the It 3, 2018 starting at 9:12 am In not aware of Patient 40's Ineal refusals. RD 2 indicated						

CENTER	& MEDICAID SERVICES				MB NO.	0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER			STR	IEET ADDRESS, CITY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENT	al Health Center			1 South avalon blyd S angeles, ca 90011		
(X4) (D PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE	(X8) COMPLETION DATE
A 621	received a "stat" or nutrition consult on she visited Patient 2. During meal obs 12:15 PM, four of the children's unit did rown of the children's unit did rown of the patients may not he may have just had the patients just had the patient size of which cleaning his room. 2018 at 12:30 PM, and also receive for Center "using food punishment, however eating habits that ye reward often leads that are high in sug Worse, it interferes regulate their eating eat when they are in themselves". Action the goal of rewarding desirable behaviors comes from inside should promote he indicated on Augustians.	passess Patient 40 when she der from the physician for a 7/26/18 but on 7/27/18 when 40, he was eating. ervation on July 31, 2018 at the eight patients present in the lot consume all their meals, bresent stated some of the laye been hungry because they snacks. CNA N1 indicated one d BBQ chips less than one and another was just given two he had consumed one, for CNA N1 stated on July 31, the patients are given snacks od as incentives and rewards. Inversity of Rochester Medical as a reward or as a ver, can undermine the healthy ou are trying to teach your eets, chips, or soda as a to children overeating foods far, fat, and empty calories. With kids' natural ability to g. It also encourages them to not hungry to reward another healthy kids.org states that and that effective rewards althy living" Both RDs than 3, 2018 at 9:15 am e that food was being used as		321	2, RD to train staff on meal timing and a meal service behavior on November 2	THE RESERVE AND DRIVE	11/20/2018
	3. During the discu Pharmacy and The	esion about participation in the repeutic (P&T) Committee, RD		,			

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STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE 6 COMPL	Burvey Eteo
		054083	B. WING	WATER COLUMN COL	08/03	/2018
NAME OF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		4211 SOUTH AVALON BLVD		
- 				LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies I must be preceded by full SC identifying information)	ID PREFI TAG		LD SE	(XB) COMPLETION DATE
A 621	AM, that they do not because they are hind scheduled to be on August 3, 2018 and attend "due to deducation, nutrition as an incentive and would be appropriate have been brought committee. 4. On August 2, 20 Manager (FSM) marger (FSM) marg	ed on August 3, 2018 at 9:48 at participate in the meetings eld on days or times they are in the hospital. RD 1 stated at 9:60 AM, the RDs also do other obligations". Physician therapy including use of food I updating of diet manuals te topics that the RDs could forward to the P&T 18 at 4:30 PM, Food Service ade changes to the pediatric as "not enough food for the concurrent interview and in response to getting RD	A	Food Service Director , RD will develop regarding food substitution. A training was to food service staff on following the proregarding food substitution.	vas provided	
	know how to reach the hospital operate did not have a syste communication exists food service staff. Oversight During the tour of the deficient practices immediate jeopard on August 1, 2018, 2018, RD 1 and RE oversight of the kitt monthly kitchen sathe August 3, 2018 have any authority nutrition staff. Diet Manual A review of the diet	enu changes, she does not the RD and would have to get or to reach them. The hospital em in place to ensure sted between the RDs and the kitchen, there were many identified resulting in y. In the interviews with RD1 and RD 1 and 2 on August 3, D2 stated they had limited chen and do in services and nitation checks. RD 1 stated in interview that the RDs do not to speak with the food and		Diet Manual will be updated and approve annual basis and training will be provide on the diet and Diet Manual.		10/26/2018
		as in 2014. The community		on the diet and Diet Menuel.		

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		054083	B. WING			08/0	3/2018
	ROVIDER OR SUPPLIER COMMUNITY MENT	al Health Center		421	REET ADDRESS, CITY, STATE, ZIP CODE II SOUTH AVALON BLVD IS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of Deficiencies Y Must be preceded by full .sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETION DAYE
A 621		age 59 oval of menu is yearly.	A	321			
	AM, both RD 1 and on not have any projects going on a past. RD 1 stated presented to the a food services. A retitled "Sanitation RD 1 from Novem showed poor labe concerns. Most of	August 3, 2018 starting at 9:12 of RD2 indicated they currently beformance improvement and did not develop any in the her monthly audits are diministrator and director of eview of the facility document eport" completed monthly by ber 2017 through April 2018 ling as one of the identified the other deficient practices as survey were however, not			On line compliance audit available for RD updated. New full time RD will conduct C are now part of the Executive Medical Co	DAPI. RDs	
A 629	THERAPEUTIC C CFR(s): 482.28(b) \$482.28(b) Menus	NETS	A	6 29	Standardized recipes are in place and control in-service will be provided. On- QAPI has been implemented with test	golng	08/25/2018
. ,	patients. (1) Individual patiemet in accordance practices.	ent nutritional needs must be e with recognized dietary			(Attachment S)		•
	Based on review records and staff ensure that the methat it met the net five-week menu c was developed by which do not have ingredients, preprits nutrient conter affect the nutrition	Is not met as evidenced by: of menu, review of clinical interviews, the hospital failed to enu was analyzed to determine eds of all of its patients. The surrently used by the hospital y different distitians and some of erecipes to determine its aration methods and therefore at. This had the potential to a status of all 50 patients he survey. In addition, the	ı				

CENTE	<u> 18 FOR WEDICARE</u>	& MEDICAID SERVICES				MB NO.	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	***************************************	*************
(JPMPNP)			.	4	211 SOUTH AVALON BLVD		
WENKEN	COMMUNITY MENT	AL HEALTH CENTER]	1	OS ANGELES, CA 90011		
/V.4\ 1P\	ATO VIGALLIA	TEMENT OF DEFICIENCIES	l	1		k f	
(X4) ID FREFIX TAG	(BACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROP DEFICIENCY)) 0E	COMPLETION COMPLETION (XS)
A 629	hospital falled to en two sampled patien were met in accord practices. These fa cf 11 pounds in 14 potential to choke in 621) Findings: A review of week 4 menu did not indica approved the menu signifies that it has appropriate in termitexture, population, disease and special among other criteria.	isure the nutritional needs of its (Patients 39 and Patient 40) ance with recognized dietary flures resulted in weight loss days for Patient 40 and in Patient 39. (Cross refer A of the five-week hospital ate the registered dietitian (RD). The approval of the menu been reviewed and deemed is of the nutrient content, cultural appropriateness, ilized needs of the patients a, by the hospital dietitian who bout the patients in that		629	Standardized recipes are in place and portice control in-service will be provided. On-going QAPI has been implemented with test trays (Attachment S).	3	08/25/2018
	hospital.	· · · · · · · · · · · · · · · · · · ·					
1	•				An In-service was conducted by the RD for	d service	09/28/2018
	During kitchen obse	ervations on July 31 and			consultant on Menu Production on		
	observed preparing recipes. On July 31 service worker (FS' with cantaloupe, ho grapes and poured quantity of drinkable	od service workers were different entrée Items without , 2018 at 1:45 PM, Food W 1) prepared a fruit salad meydew melon, pineapple and over the fruit unmeasured e yogurt. In a concurrent vation, FSW 1 stated there he fruit salad.			Seplember 28, 2018 (Attachment T).		
	interviewed on the prepare the Cheese prepared for dinner a recipe but followe the Enchiladas. Acc	at 3:00 PM, Cook 1 was preparation methods used to enchilada that had been a Cook 1 said he did not have did the directions on the box of cording to the menu, patients a to be served 3 ounces of			·	•	: :

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED		
		054083	8. WING	···		08	1/03/2018		
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTH AVALON BLVD DS ANGELES, CA 90011	Ε,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of deficiencies / Must be preceded by full 8C identifying information)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X6) COMPLETION DATE		
A 629	clear if the other ing make the cheese e size on the box of the two enchiladas protein. If the 3 ounces, the protein content ounces, the amount less than 3 ounces protein, the two enchilates there were seven planned on the median there were seven protein on the diet. During August 1, 2018 at 1 portions diet were one wing of BBQ clobservation and introducible protein on all meals there were increase such as bread, veg double the vegetab	pake casserole. It was not gredients were required to inchilada bake. The serving he Cheese enchilada was two. It will provide 17 grams of it will provide 17 grams of it will provide 18 grams of it will provide 18 grams of it of the enchilada given was it inchiladas were 17 grams (or 2 in, four grams less than was nu. It will be the control of it will be the inchiladas were to serve patients meal service observation on 10:47 AM, patients on double served a chicken breast and inchiladas. Cook 2 in a concurrent erview stated the patients on its were to receive double the its but was unclear whether its for other items on the meal etables. Cook 2 dished out le (broccoil) after the surveyor he breast and wing served	A 6:	29	Training for the new menu and recipes a with kitchen staff.	re on-goin			
	starting at 9:12 am, of the serving of do double meat but un 2 provided a docun Regular diet and D 3/1/12. According to double portions die	RD 1 on August 1, 2018 , RD 1 stated she was unsure ruble portion, believes it was usure of the exact amount. RD nent titled "Menu pattern buble Portions Diet" dated to the document, patients on t receive double the serving of two boxes of cold cereal					1		

versus one for patients on regular diet, four slices

		& MEDICAID SERVICES			O	MB NO.	0938-0391
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VEDOEN	l Marinal Indian Alestra	A 3 E 2000 A 2 Note a programme		4;	211 SOUTH AVALON BLVD		
(VEDIVE)	I COMMUNITY MENTA	AL REALIN CENTER		L	OS ANGELES, CA 90011		
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A 629	of bread vs two slic patients on double protein versus 3 ou diets. The DP diet r	es during breakfast. For lunch, portions receive 5 ounces of nces for patients on regular eceive double starch, ple wheat bread. For dinner,	A	329	A new menu is now in place. Training food staff on using the menu and recipes are caby the consulting food service RD.		
	showed limited varivegetables offered. Items from one mer For example on 7/3 cheese sauce was patients were serve Wednesday 8/1/18, vegetable for lunch vegetable for dinne mashed potato on I Wednesday for lunch on Thursday dinner also on Thur roasted red potatos kind of nutrients a p	of the five- week menu ety in the starches and There were repetition of food at to another or day- to-day. 1/1/18, Tuesday, broccoll with served for lunch. For dinner, and bean broccoll salad. On a peas/glazed carrots was the and glazed carrots was the and glazed carrots was the r. Patients received garlic Monday for dinner, ch, oven browned potatoes for and mashed potatoes for raday. For Thursday lunch, as Meal repetition limits the patient will receive and may reduced satisfaction.	•				
n de la companya de l	evaluate the adeque that it would meet to patient population it	enu had not been analyzed to lacy of nutrients and validate he nutritional needs of the because the hospital did not program that analyzes menus Cross refer A629)					
And Andread An	was admitted to the diagnoses of diabe diagnoses. Diabets the body does not	ratient 39 showed Patient 39 a hospital with medical tes in addition to psychiatric as a medical condition in which produce enough insulin and sugar. The physician	.				,

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
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		054083	B. WING	out mensor after the first the control of the contr	08/03/2018
	PROVIDER OR SUPPLIER N COMMUNITY MENT	AL HEALTH GENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX YAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	atement of deficiencies Ly must be preceded by full LSC identifying information)	ID PREFI TAG		CTION (XS) DULD BE COMPLETION ROPRIATE DAYE
A 629	diabetic diet. The Association) diet is statement in 2002, the term "ADA diet ADA no longer end specified percente done in the past". showed that the R 2000 Cal ADA diet RD 2 in the same starting at 9:12 AM served because the physician. RD 2 stated that the ducated on the froutdated. A review	2000 Cal (calorie) ADA diet- ADA (American Diabetic an outdated diet. In a position the ADA "recommended that t" no longer be used, since the dorses any single meal plan or tiges of macronutrients as it has A review of the 2018 menu Ds had an 1800 Cal ADA and ts as part of the diets offered. Interview of August 3, 2018 A stated that the diets were nat was what was ordered by the physicians were not act that the ADA diet was the of the facility diet manual	A	329 New EMR will facilitate, and the availate information to all involved will improve and plan of care. New menus include the required. Production start date 01/01/20 Diet orders were updated in the new EM	assesements ne recipes 219,
	carbohydrate diet. medical director (I AM, MD stated the about the needs of was not aware the Nutrition Assessm In an Interview wit starting at 9:10 Alf are assessed with provided a docum Intake Pattern Ca Indicated used in patients. The chai based on sex, ag- into consideration	let listed was the consistent In an interview with the MD) on August 3, 2018 at 11:35 at the RDs did not inform him if the department. MD stated in ADA diet was outdated. It is a consistent of the consistent o	,	New Menu will provide nutrition analysize, in-service on Menu Production is provided to food service staff.	

. According to the 2006 ADA (American Dietetic

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	. Verkelangrap dabbahan	054083	B. WING	***************************************		08/03/2018
NAME OF F	ROVIDER OR SUPPLIER			Sĭ	REET ADDRESS, CITY, STATE, ZIP CODE	
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER			11 SOUTH AVALON BLVD	
				L	OS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLÉTION
A 629	of Practice Indicator health "completes a indicators to evalue and correlate one padvanced clinical jubilistic focus of bei complex disorder) A review of five clin chart was used to call the patients. The of the nutritional nereviewed. The curre evaluate caloric, proceedings of Nutritic "the Mifflin-St Jeor (equation to use for normal and obese in kilogram body weigneeds and 30 millillikilogram body weigneeds. In the intervo August 3, 2018 stat that she was award done with calculation fluid and does so in another level of cardone so at this hos present during the any rationale as to the current practice calculations and for Menu There was no differ	Registered Dietitian Standards rs, stated the RD in Behavioral a more detailed analysis of the steep the complexity of problems problem to another (i.e. using adgement skills reflecting the navior health care as a sical records showed that this determine the caloric needs of see were no complex analysis eds of each of the patients ent standard of practice is to otein and fluid needs. The on and Dietetics (2017) states equation is the most accurate restimating nutrient needs) for individuals. 0.8 gm per that is the calculation for protein iters (a measure of volume) x that is the calculation for fluid flew with RD 2 and RD 1 on ring at 9:12 AM, RD 2 stated to for nutrition assessments on calories, protein and in her consultant practice in rebut that they have never pital. Neither RD 1 who was interview and RD 2 provided why they never implemented of for nutrition assessment rmula at the hospital.	· A€		The new EMR - Avatar developed to offer canalysis of the nutritional needs of each pat therapeutic needs and a plan of care.	
		. Tuesday and Wed, same for a smounts for other days were	· ·	1	ı	

identical with the exception of few entrees. The

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>)MB NO. 0838-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		054083	B. WING			08/03/2018	
NAME OF F	PROVIDER OR SUPPLIER		i i	STREET ADDRESS, CIT	TY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENT	AL HEALTH CENTER		4211 SOUTH AVALOR	N BLVD		
				LOS ANGELES, CA	A 90011		
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A629	age group of the ch - 12 years old. According to the characteristics of the characteristics	ge 65 illdren during the survey was 6 ording to the hospital by the RDs titled MyPyramid n Calorie Levels" by the USDA the children in this age group	A6	29	,		
	is between 1200 to activity. Serving the adults whose calor calories is not appr	1800 calories for sedentary same food to children and c need is 2000 to 2600 opriate. Excessive amounts of overeating resulting in		·		,	
	including schizophi food was being poi eat. The physician' regular diet and nu times a day. Nursir 40 consuming mea admission through transferred to the a refused all nutrition through 8/2/18. Paradmission, lost 11 transferred to an arehydration. A 7.9 a severe weight los standard of practic 5% in one month is	dmitted with diagnoses enia. Patient 40 believed his soned and so he refused to a order for Patient 40 was a tritional supplements three g staff did not observe Patient is from 7/12/18, date of 7/26/18 when he was cute care hospital. Patient 40 al supplements from 7/12/18 itent 40 weighed 138 lbs. on bounds in 14 days, before was cute care hospital for 6 weight loss in two weeks, is so According to current a weight loss of greater than a severe.		Nursing provides R	assessments per tocal p tD consults at briefs for meals and poor intaks.	•	
	RD completed a nu of admission. The assessments or do continued to refuse Nursing notes indic provide meals in se	aw of Patient 40 indicated the itrition assessment on the day RD did not complete any other currentation when Patient 40 meals and lost 11 pounds. Pated that nurses attempted to paled containers to reassure als were not tampered with. In					

		8 MEDICAID SERVICES					<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GL/A IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		8	STREET ADDRESS, CITY, STATE, ZIP CODE	- 	***************************************
KEDREN	COMMUNITY MENT	AL HEALTH CENTER			1211 SOUTH AVALON BLVD		
		•		L.	LOS ANGELES, CA 90011 ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL LSC IDENTIPYING INFORMATION)	PREF • TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETION DATE
A629	an interview with LI 12:30 PM, LN N10 offered "cup of noo prepared by adding The container had item and may have did not consume it, such as some pact been offered to Pat been opened to pre service manager (f PM stated that they that they occasiona those on Kosher di	age 66 N N10 on August 2, 2018 at indicated Patient 40 was odie". Cup of noodle is g water to dehydrated noodle, to be opened to prepare the e contributed to why Patient 40. Other prepackaged products kaged dinners, could have tient 40 that would have not epare and serve. The Food FSM) on August 2, 208 at 4: 25 y have prepackaged products ally obtain for patients such as lets that would have been lient 40 had the RD requested	AI	629	RD will continue to train nurses on how to he nutritional requests. In addition, RDs will attenuately Nursing Meetings.		
	refer Patient 40 to same interview that protocol to call the they call the physic August 3, 2018 state was not aware his meal refusals. It to reassess Patient order from the phys 7/26/18 but on 7/27 40, he was eating of the consult. 2. During meal obta12:10 PM, in the actions and the consult.	iged the nursing staff did not the RDs, LN N10 stated in the it it was not part of the hospital RD if a patient does not eat, clan. RD 2 in the interview on inting at 9:12 AM stated that of Patient 40's weight loss and RD 2 indicated she attempted t 40 when she received a "stat" sician for a nutrition consult on 7/18 when she visited Patient There was no documentation servation on August 1, 2018 at dult in-patient unit, Patient 39					
	mashed potato in a additional containe described as soft d billing into the BBQ	lowing: BBQ Chicken, broccoli, a container. She received an ir with yogurt, jello which was liet. Patient 39 had difficulty to chicken. Patient 39 moved the st along every area of her	•				;

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		054083	B. WING	-	ANT Provides that the following highly provided by the decision which the contract of the following the contract of the contract of the following the contract of the	08/0	3/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 211 SOUTH AVALON BLVD OS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(XB) COMPLETION DATE
A 629	bite into it. About a out of her mouth ar with her hands and meat in her mouth. choke. The nursing	ge 67 Into the chicken and could not minute or so later she pulled it of tore off pieces of chicken shoving large pieces of the It tooked like she was going to staff in the room did not down or offer to cut the food.	A	329	A nursing staff is always available in the din with patients. Pt 39 refused to eat mechanic food, and requested regular foods. Pt 39 ha in the facility since Dec 12, 2017, has been eating regular foods with no chocking issues	celly soft is been	
	(no teeth). Review of Patient 39 was admissiven and a half missiven assessed by the RI marked that she die	d Patient 39 was edentulous of clinical record showed hitted to the facility about onths before and had been alorie ADA diet. She had been 0 on 12/15/17. The RD in not have difficulty chewing or was no other documented iD reassessed her.			RDs provide re-assessments per local poli- Nursing provides RD consults for chewing/ difficulties. Care Plans implemented in the to address problems identified in RD asses (Attachment V	swallowing new EMR	
	Interdisciplinary Plack of teeth as a pplan under the headletary issues at the documentation in hino teeth or use of cCNA N2 on August stated Patient 39 wensure that the die to prevent choking. RD 2 in an interview AM, stated Patient and would want reg There was no document 39 would not be prevent and would not be patient 39 would not be prevent and would not be patient 39 would not be placed to prevent and would not be patient 39 would not be placed to placed the placed to placed the placed to placed the placed to placed the placed the placed to placed the placed to placed the placed to placed the	ster treatment Plan - in of care did not identify her robtem. On 2/23/18, the care ding Dietitian, stated "No is time". There was no er clinical record that she had lentures. In an interview with 2, 2018 at 11:30 AM, CNA N2 ces not have teeth "but she as not properly assessed to and texture were appropriate of and texture were appropriate of on August 3, 2018 at 9:48 39 would not eat ground meat gular meats from the menu, imented evidence that the of eat the food of the to prevent accidental choking.	•				

Patient 39 was not reassessed after the initial assessment. Professional standards of practice

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
·VIIII TANGET MARKET THE COLUMN TO THE COLUMN TO THE COLUMN THE CO		054083	B. WING	سنيسو		08/(3/2018
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VENDEN	COMMENTATIVE SACRET	al Health Center	-	42	11 SOUTH AVALON BLVD		
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A 629	There was no polic	ige 68 ant of patients in a hospital. y in place that guided the assessment will be conducted.	A	329	New EMR addressing the follow up assess meeting professional standards.	ment and	01/01/2019
,	12:15 PM, four of the children's unit did in CNA N1 who was parted some of the hungry because the CNA N1 indicated cohips less than one another was just glinad consumed one N1 stated on July 3	ervation on July 31, 2018 at the eight patients present in the lot consume all their meals, bresent during the observation patients may not have been by may have just had snacks, one the patients just had BBQ thour before lunch and ven two cupcakes, of which he is, for cleaning his room. CNA 11, 2018 at 12:30 PM, the snacks and also receive food ewards.		,	RD will train and educate staff on timing of and appropriate /meal serving behavior.	f meals	12/01/2018
	Center "using food punishment, however eating habits that y children. Giving sw reward often leads that are high in sug Worse, it interferes regulate their eatin eat when they are themselves". Actio the goal of rewardidesirable behavior comes from inside should promote he indicated on Augus not aware that food incentive or reward	niversity of Rochester Medical as a reward or as a ver, can undermine the healthy ou are trying to teach your reets, chips, or soda as a to children overeating foods par, fat, and empty calories. It also encourages them to not hungry to reward infor-HealthyKids.org states that ng is to help internalize and create motivation that eard that effective rewards waithy living Both RDs at 3, 2018 at 9:15 AM they were d was being used as an I in the children's unit.					
		ission about participation in the erapeutic (P&T) Committee, RD	,		:	·	

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""	ROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER		4211	ETADDRESS, CITY, STATE, ZIP CODE SOUTH AVALON BLVD ANGELES, CA 90011	٠		
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A 629	AM, that they do n because they are not scheduled to be an action, nutrition as an incentive an would be approprihave been brough committee. 5. On August 2, 2! Manager (FSM) n menu because it children". FSM in observation states approval for diet/r know how to react the hospital operadid not have a sy	ted on August 3, 2018 at 9:48 of participate in the meetings held on days or times they are te in the hospital, RD 1 stated at 9:50 AM, the RDs also do other obligations". Physician in therapy including use of food displaying of diet manuals ate topics that the RDs could at forward to the P&T. 218 at 4:30 PM, Food Service hade changes to the pediatric was "not enough food for the as concurrent interview and in response to getting RD menu changes, she does not he the RD and would have to get tor to reach them. The hospital stem in place to ensure wisted between the RDs and	A	Pr pr th	estructuring the Dietary Dept to include rovide training, education and should i not the pt nutritional needs are met acc his includes being an RD representative sectings.	meet and ensure ording to standard.		
	Patient (CIP) unit Patient 24 asked were no water cu source of water in being consumed. during the meal to	servation in the Children's in on July 31, 2018 at 12: 20 PM, for water while eating. There ps, pitchers or other visible at the room where the meals was The CNA N1 who was present old the patient there was juice of the meas not provided water				:		
	12:10 PM the Adasked for ice. The	ervation on August 1, 2018 at uit in patient unit, Patient 38 had e Mental Health Techniclan rvised the patients stated there ible. Patient 38 continued to ask						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''	riple construction ng	(X3) DAT	TE SURVEY MPLETED
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KEUREN	COMMUNITY MENT	al Health Center		Los angeles, ca 90011		
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A 629	ice getting louder. I container that held provided to Patient a potential source of ln an interview with 12:30 PM, MHT staccess to water. In service Manager (F 4:05 PM, FSM stat	ice, baby" with the request for MHT scooped ice from the the frozen dessert and 38. This ice could have been of contamination. the MHT on August 1, 2018 at ated the patients only have an interview with the Food FSM) on August 2, 2018 at at there is no water on the ot provided. FSW also stated	A 6:	29 1) in-service staff on infection control 2) Request a container of ice for the producing meals. 3) Staff will be given pre/post test on for bacterial growth. 4) Monthly audit and tracking refrigeration implemented. 5) Observe Meal Pass weekly for one monthly thereafter. Responsible individual: Nursing Super DON. A secure water container is always ava-	or content will month and the visor and/or	n
A 630	3, 2018 starting at kitchen does not provide the killway when water. She did not asked if the expect leave the table to describe the control of the patients. DIET'S CFR(s): 482.28(b): All patient diets, inche ordered by a procare of the patient, qualified nutrition patient of the medical staff a law governing dietiprofessionals.	cluding therapeutic diets, must actitioner responsible for the or by a qualified dietitian or professional as authorized by and in accordance with State tians and nutrition	A6	Water fountain is available all the time.	•	मसु सहस्रा आस्ट
	This STANDARD	is not met as evidenced by:		,		

		& WEDICAID SERVICES	Y			<u>OMB NO</u>	.0938-0391
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NAME OF F	PROVIDER OR SUPPLIER	V		8	FREET ADDRESS, CITY, STATE, ZIP CODE	***************************************	
KEDREN	COMMUNITY MENTA	M NEALTH CENTED		43	HI SOUTH AVALON BLVD		
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	Continued From pa Interviews, the facili	ty falled to ensure that diet	Αŧ	330	EMR charling will ensure the that patients diet order requested by the MD or the regi	will have stered RD,	12/10/2018
	orders were ordere	d by the practitioner			A QAPI for Diet Orders will be implemente	id on	
	sampled patients (F	care of the patient. Two Patients: 37 and 38) did not escribed by their physicians;			December 10, 2018.		
	Findings:						
•	patient was admitte including bipolar dis order a diet for the p served a Regular di regulation list for Au	w for Patient 38 indicated the d on 7/31/18 with diagnoses torder. The physician did not patient. The patient was et. According to the Diet argust 1, 2018. During meal t 38 received a regular diet.					
	the Physician Admis was ordered for the order was not identi completed a Nutrition	ailted on 8/1/18. A review of asion orders showed no diet patient. The lack of a diet fied by the RD who had on/Dietary assessment on was served a regular diet.	٠				
Δ 70 0	12:30 PM, LN N2 st the order was not a			100	•		
n IVV	CFR(s): 482.41	Maiaieta I	Αï	'00			
	maintained to ensur and to provide facili- treatment and for sp	e constructed, arranged, and the safety of the patient, tiles for diagnosis and pecial hospital services eeds of the community.				,	
	This CONDITION I	s not met as evidenced by:					

PRINTED: 10/10/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 054083 B. WING 08/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4211 SOUTH AVALON BLVD** KEDREN COMMUNITY MENTAL HEALTH CENTER LOS ANGELES, CA 90011 Provider's plan of correction (Each corrective action should be cross-referenced to the appropriate deficiency) SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PREFIX ID COMPLETION PREFIX TAG TAG A 700 Continued From page 72 A 700 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 falling 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) 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)

to A 701)

9. Maintain posted warning signage of water that is 120 oF (degrees Fahrenheit) or higher. (Refer

10. Provide documented evidence of an

	TO TOTAL TRANSPORT	CANICIONAL OF CALCALOTTO					<u> VIVIE</u>	J NO.	1830-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILL		CONSTRUCTION	·	(X	3) DATE COMP	SURVEY LETED
		084083	B. WING	·				08/0	3/2018
NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CIT	Y, STATE, ZIP CODE			
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		1	1 80UTH AVALON 8 ANGELES, ČA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	8 PLAN OF CORRECTIVE ACTION 8HO ENCED TO THE APP DEFICIENCY)	VLD BE	LO BE COMPLETION	
A 700	A 700 Continued From page 73		A.	700			•		
	assessment condu- of emergency wate to A 703)	cted to determine the quantity r needed by the facility. (Refer	٠.						
	emergency general	t glass of the fuel gauge at the tor's day tank so that the fuel uld be read. (Refer to A 709)	ė						
	12. Maintain the ma of storage. (Refer to	ain electrical panel room free o A 709)	•						
·	13. Maintain the ma boller room walls fn 709)	ain electrical panel room and se of penetrations. (Refer to A					•		
,	14. Maintain the sto of penetration. (Ref	prage room comdor door free er to A 709)							
	15. Maintain the Inf server room ceiling A 709)	crmation Technology (IT) free of penetrations. (Refer to				•			į
	16. Maintain smoke penetrations. (Refe	and fire barriers free of r to A 709)							į
	17. Maintain patient limited combustible	t room walls of combustible or construction. (Refer to A 709)			·	•			
	18. Maintain exit do 709)	ars unobstructed. (Refer to A							
	19. Ensure corridor shut. (Refer to A 70	doors can hold closed when 9)							·
	20. Maintain a corri 709)	dor door in place. (Refer to A	,					-	
	21. Maintain an astr	zaal at corridor Dutch door.			•				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MU A. BUILO		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	•	054083	B. WING	3		80	3/03/2018	
		TAL HEALTH CENTER		4211	REET ADDRESS, CITY, STATE, ZIP COD 11 SOUTH AVALON BLVD 8 ANGELES, CA 90011	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREP TAG	PIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	KOULD BE	(X6) COMPLETION DATE	
A700	Continued From p	page 74	· A	700				
	signage ayailable :	signage and exit directional and unobstructed from view, he occupied area. (Refer to A		•				
	cabinet readily acc	extinguisher and hose in corridor cessible by maintaining a inet door. (Refer to A 709)						
:	24. Maintain fire en not damage hose.	extinguisher properly hung as to (Refer to A 709)	•					
		8 inch clearance between the kler head deflector and the top to A 709)			•			
	26. Maintain electr damage. (Refer to	irical cover plate free of o A 709)	,	r				
•	27. Maintain Kitch caps in place: (Re	nen suppression system blow off efer to A 709)						
		xygen cylinders secured, rom full and identified by posted > A 709)			,			
:	29. Correctly use of strips. (Refer to A	extension cords including power 709)			·	•		
	30. Maintain docus and testing of drop plates legible. (Re	rmented evidence of inspection p down fire doors, and rating efer to A 709)				•		
		mented evidence of sensitivity ectors. (Refer to A 709)	•				! i	
		mented evidence that the						

PRINTED: 10/10/2018 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BUILDING 054083 B. WING 08/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD KEDREN COMMUNITY MENTAL HEALTH CENTER LOS ANGELES, CA 90011 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X6) COMPLETION DATE PREFIX DEFICIENCY A 700 Continued From page 75 A 700 (Refer to A 709) 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)

CENTER	10 LOK MEDICAKE	A MEDICAID SERVICES			V	IND INO, UBSO-USB
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING	****		08/03/2018
NAME OF F	PROVIDER OR SUPPLIER			81	FREET ADDRESS, CITY, STATE, ZIP CODE	
		A 2 . J. C. 200 A A. Sark A. Alle Carrier (1946 1946 1946 1946	- 1	42	211 SOUTH AVALON BLVD	
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER			OS ANGELES, CA 80011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIL TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
A 700	Continued From pa	nae 76	A 7	' '00		
1111		ect of these systemic problems	743	uu	,	
	resided in the Earl	ility's inability to ensure the				
	nrovielon of quality	health care in a safe and				
	sanitary environme					•
A 701		F PHYSICAL PLANT	Δ7	ነስ4	A 701 Plan of Correction # 1	
7171	CFR(s): 482.41(a)	I FITTOIONE FENNT	<i>(X)</i>	VI	The air return and supply registers in the dis	elarv
	O1 17(0), 402,41(0)				storage room were cleaned by the Kilchen i	
	The condition of the	e physical plant and the overall			this findings will be monitored during the sai	
	hospital environme	nt must be developed and			and reported to the quality management dep	
	maintained in such	a manner that the safety and			on a monthly basis for work order completion	n status by
	well-being of patier	nts are assured.			the engineering department ATTACHMENT # 1	
-	Based on observa failed to develop ar	s not met as evidenced by: tion and interview the facility nd maintain the physical plant ssured the safety and nts.		-		
	environment may o	naintenance of the physical compromise the medical status ability for staff to care for				
	Findings:	•				
	Basement	•				
	observed that in the	0:46 a.m., the evaluator e dietary storage room there on of dust at a celling air return				
	On 8/1/18 between following conditions	8:30 am and 2:30 pm the sexisted at the facility.				
	1st Floor Kitchen				•	*

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING		08/03/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	T OOIOOIXU 10
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		4211 SOUTH AVALON BLVD LOS ANGELES, CA 80011	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	itement of deficiencies / Must be preceded by full 8C identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (KS) DBE COMPLETION RIATE DATE
A701	water at the hand w result of 120 oF (de observation reveale	ge 77 served the temperature of the served the temperature of the served with a grees Fahrenheit). Further d there was no posted eign 20 of water temperature.	A 70	A 701 Plan of Correction #2 The motion activated faucet in the hand wa was removed and replaced with a hand act faucet and the water temperature was adjust accordingly on 08/03/2018 ATTACHMENT #2	ivated
÷	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.				·
	application bottle co an electrical conduit	served there was a squeeze ontaining machine oil laying on t next to a reach in refrigerator se at cooking area of the		A 701 Plan of Correction # 3 The lubing oil squeeze application bottle was permanently removed by the food serviced I and properly discarded of on 08/01/2018. NO ATTACHMENT	08/01/2018 8 Director
	observation a kitche	at the same time as the en staff stated that oil was w on the cooking equipment.			·
	The evaluator ob foot accumulation o of a tiled wall in the	served there was a 2 vertical f black material at the corner dishwashing area.		A 701 Plan of Correction # 4 The tile area around the dish washing area scleaned by the Housekeeping cleaning crew	
·	observation the Dire	at the same time as the actor of Facilities stated the laily, but that spot must have		08/03/2018 ATTACHMENT # 3	
	2nd Floor Administr	ation			
	5) The evaluator ob water damage inclu ceiling of the confer	served there was sign of ding brown staining at the ence room.		A 701 Plan of Correction # 5 The water damage in the board room was re the engineering department on 10/15 2018 ATTACHMENT # 4	10/15/2018 spaked by

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WING			08/0	3/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 211 SOUTH AVALON BLVD OS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Y Must be preceded by full SC Identifying Information)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
A701	patient common ba	n Patient (CIP 2) served two of three men's throoms had standard faucets as anchor points to tie to that	A		A 701 Plan of Correction #6 All of the bathroom faucets in the Adult in Pati (AIP-2 & AIP-2) and Children in Patient Unit (r have been purchased and will be replaced with proof faucets by the engineering department 11/30/2018 ATTACHMENT #5	CIP) h ligature	11/30/2018
	observation the Dire the patients go into unaccompanied. The stated that they orde that the standard fa with the anti-ligature out.	ne Director of Facilities also ered anti-ligature faucets, but sucets had not been replaced e faucets because they ran eserved the doctor's office had	·		A 701 Plan of Correction # 7 All of the ceiling tiles in the Dr's office was rep the engineering department on 08/06/2018 ATTACHMENT # 6 A 701 Plan of Correction # 8 The dining room clock battery was replaced or 08/03/2018 and time was set accordingly by the engineering department ATTACHMENT # 7	aced	08/03/2018 ·
	wall clock that was 9) The evaluator ob was peeling and mi- unfinished porous p Housekeeping prov to clean and disinfe products' labels, inc	served that in room 212 there issing paint at a wall, exposing plywood surfaces. Ided labels of products used ict the patient room walls. The pluding the product used for indicated that the product was			A 701 Pian of Corrections # 9 Room 212 was painted by the engineering de on 08/08/2018 all of the existing plywood on the AIP and CIF will be removed and walls will be repaired to original condition Please refer to: K 163 Pian of Corrections ATTACHMENT # 8	² units	08/06/2018
	3rd floor Adult In Pa	•	•			:	
	that could be used a can hold a person's	bserved there were fixtures as anchor points to tie to that weight throughout the unit; link drain line and standard	: : !	•			

PRINTED: 10/10/2018 FORM APPROVED OMB NO. 0938-0391

APLATICA LOV		O MEDICAID SERVICES			OMB NO	<u>), 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION ING	(X3) DAT	TE BURVEY MPLETED
	•	054083	B. WING		08	/03/2018
NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		TOURS
KEDREN COMMU	NITY MENT	AL HEALTH CENTER		4211 SOUTH AVALON BLVD LOS ANGELES, CA 88011		
PREFIX (EA	CH DEFICIENC'	Tement of Deficiencies Must be preceded by full Scidentifying Information)	(D PREF TAG	PROVIDER'S PLAN OF CORREI X (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
A 701 Continu	ad Erem as	70				

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 358 the top hinge of the corridor door was loose causing the door to drag against the floor.

A701

A 701 Plan of Correction # 10

The Missing under sink Cove was replaced in patient room # 375 by the engineering department on 08/08/2018 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 358 please refer to:K 383 Plan of Correction # 2

	TO LOW MEDIOVICE	WINEDIAVID SELVICES			MIN IAO	1 6550-0591
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE COMF	SURVEY PLETED
		054083 `	6. WING		08/0	3/2018
NAME OF F	PROVIDER OR SUPPLIER		ĺ	STREET ADDRESS, CITY, STATE, ZIP CODE		
KEUDEN	COMMUNITY MENTA	AI WEAITW CENTED	l	4211 SOUTH AVALON BLVD		
NEUNCI	ANIMALIE I MEMI	ne manual vention		LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Y Must be preceded by full SC Identifying Information)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP) BE	(XS) COMPLETION DATE
A 701	Continued From pa	nna 80	Α7	· ·		
, , , , ,		observed in rooms 341, 345	***	A 701 Plan of Correction #13		
		and missing paint at a wall,		All the Existing Plywood will be removed fro	m the AIP	
		d porous plywood surfaces.		and CIP units Please refer to: K 163 Plan of Correction		
	Darrantsammina man	Natural designature of several several several		Ligand later for 17 100 Limit of Correction		
		rided labels of products used act the patient room walls. The		·		
	products' labels, inc	cluding the product used for				
	terminal cleaning, is	ndicated that the product was				•
	to be used on non-	porous surfaces.				
	3rd floor Adult in Pa	atient (AIP 2)				
	that could be used can hold a person's	observed there were fixtures as anchor points to tle to that s weight throughout the unit; sink drain line and standard	,	A 701 Plan of Correction # 14 The missing under sink cover was replaced 313 on 08/05/2018 all of the bathroom g faucete will be replaced with ligature resists Please refer to: A 701 Plan of Correction #	nt faucets	08/05/2018
		bathroom sink had exposed tould be used as anchors.		Elegad ididi loʻV toʻt Listi ot gottanidi il		
	observation the Dir acknowledged the	exposed pipes, stated that the was missing and the pipes				
	including those in r	erved patient room bathrooms, coms 312, 313 and 317 had nat could be used as anchors.	•			
	stated that he had thinking they were the manufacturer's were NSF (Nationa for use in health fa	r the Director of Facilities recently replaced the faucets anti-ligature faucets because literature stated the faucets as Sanitation Foundation) safe cilities. The Director of the faucets could be		regional visit of the control of the		

PRINTED: 10/10/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 054083 B. WING 08/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD KEDREN COMMUNITY MENTAL HEALTH CENTER LOS ANGELES, CA 90011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY A 701 Continued From page 81 A 701 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 faucats dld 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 The CIP Entrance door closer was adjusted by the 08/05/2018 observed that the entrance door of the CIP Unit engineering department on slammed shut during ingress and egress. 08/05/2018 NO ATTACHMENT

close quietly.
A 703 EMERGENCY GAS AND WATER
CFR(s): 482.41(a)(2)

again slammed shut.

There must be facilities for emergency gas and water supply.

On 8/3/18 at 8:45 a.m., it was noted that the door

On 6/3/18 at 2 p.m., during an interview, the Director of Materials Reprocessing stated he would have the door adjusted so that it would

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

CENTER	<u> 18 FOR MEDICARE</u>	E & MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	Q	<u>MB NO. 0938-0391</u>
STATEMENT	r of deficiencies OF Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		054083	B. WING			08/03/2018
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE,	ZIP CODE	
KEDREN	I COMMUNITY MENTA	AL UPALTH CENTER	1	4211 SOUTH AVALON BLVD		ļ
***************************************				LOS ANGELES, CA 90011		
(X4) ID PREPIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREPI) TAG		TION SHOULD THE APPROPI	BE COMPLETION
A 703	Continued From pa	ige 82	Α7	′03	,	
	in inadequate suppl for other purposes in a disaster affecting	tice had the potential to result by of drinking water and water to all patients and staff during the hospital and effectively and personal care needs of	·			
	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.			A new Water Faiture Policy Se to the emergency operations p this policy section will be preso management committee for rethe October 24, 2018 emergen committee meeting, committee in sendent in the new solley of	2018. mergency roval on ent be	
•	Coordinator stated	s the plan review the Disaster that the Dietary Director had he quantity of water needed.		in-serviced in the new policy so please refer to: E 015 Plan of 0 ATTACHMENT # 9		
A 709	by the Dietary Direct not include an asset	riew of the documents provided ctor revealed that they also did essment had been made ntity of water needed. DM FIRE	A 70	709		
	Life Safety from Fire	.				
	Based on observati review, the facility fa	s not met as evidenced by: tion, interview and document alled to ensure that the life uirements were met.				·
	minimum requireme	the potential to not provide the ents of the Life Safety Code des and Standards.		,		

PRINTED: 10/10/2018 FORM APPROVED

		& MEDICAID SERVICES			OMB NO.	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE	
,	•	054083	B. WING		00/0	amaan l
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	3/2018
KEDREN	COMMUNITY MENT	AL HEALTH CENTER		4211 SOUTH AVALON BLVD LOS ANGELES, CA 80011	,	٠
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	Tement of deficiencies / Must be preceded by full sc identifying information)	ID PREFI TAG		LD BE	(X8) COMPLETION DATE
A709	Continued From pa	ge 83	Α7	709		
	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.		٠	A 769 Plan of Correction #1 Cummings Pacific will install a new fuel ga Emergency Generator fuel tank on 11/23	uge on the	11/23/2018
-				This finding will be addressed on the July life safety Reg-4 testing	2019 fire	
				please refer to: E 041Plan of Correction # ATTACHMENT # 10	1	
	observation, the Ma	at the same time as the echanical Engineer stated that w much fuel was in the day puld not read the fuel gauge.				
- II	the observation, the	terview at the same time as Director of Facilities stated ther way to determine how e tank.		A 709 Plan of Correction # 2 All of the stored items were removed from electrical room on 08/01/2018 this findings will be monitored during the s	the main	08/01/2018
	Basement			and reported to the quality management on a monthly basis for work order complet	lepartment	
	panel room was us fixtures, a ball, and mirror. The items w	served the main electrical ed to store three celling light a large 4 foot by 5 foot framed ere located between the main		the engineering department please refer to: K 511 Plan of Correction # ATTACHMENT # 11	·	
		served the main electrical		A 709 Plan of Correction # 3 The fire penetrations in the main electrical Sealed with fire retardant material on 07/3	room were 1/2018	07/31/2018
		two-inch diameter penetration parating the main electrical		please refer to:K 321 Plan of Correction # ATTACHMENT # 12	1	
		e maintenance shop.		A 709 Plan of Correction #4 The Two Inch diameter penetration in the		07/31/2018
	4) The evaluator of two-inch diameter p	served the boiler room had a penetration through a wail.		has been sealed with fire retardant mater 07/31/2018 please refer to: K 321 Plan of		2

07/31/2018 please refer to: K 321 Plan of Correction # 2 ATTACHMENT # 13

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					1938-0391
STATEMENT	OF DEPICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		054083	B. WING			08/0	3/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KEDREN	COMMUNITY MENT	AL HEALTH CENTER		•	211 South Avalon Blyd OS Angeles, CA 80011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE	COMPLETION DATE
A 709	corridor door had a	age 84 bserved the shop storage room a missing lookset, creating a penetration through the door.	A	709	A 709 Plan of Correction # 5 The missing lock set in the shop storage replaced on 07/31/2018 ptease refer to: K 321 Plan of Correction # ATTACHMENT # 14	ŕ	07/31/2018
	observation, the Di the penetration the the removal of a lo	v at the same time as the irector of Facilities stated that ough the door was caused by ckset, that he did not know hen it was removed, and that out he there.					07/31/2018
	6) The evaluator of there was a fire ex by the base its hose During an interview observation, the Dacknowledged that	bserved that in the fan room tingulsher that was being hung se onto a bracket. v at the same time as the irector of Facilities t the extinguisher was in a manner that could damage			A 709 Plan of Correction # 6 The fire extinguisher was replaced on 07/ with the right extinguisher type to fit in the bracket, Please refer to: K 356 Plan of Co this will be monitored during the existing r extinguisher inspection by the engineering Attachment # 15	existing rection # 1 nonthly fire	,
	7) The evaluator of records room, the obstructed from full a storage bin and	bserved that in the medical second exit door was illy opening by a shredding bin, a wire basket.		•	A 709 Plan of Correction # 7 The Shredding Bin, Storage bin, and cha were permanently removed from the mer on 07/31/2018 this findings will be monits the safety tracers and reported to the que management department on a monthly b order completion status by the engineeric	ilcal records ered during ality asis for work	
	observation, the D	w at the same time as the lirector of Facilities It the exit door was obstructed			please refer to: K 211 Plan of Correction: ATTACHMENT # 16 A 709 Plan of Correction # 8 New self luminous exit algas have been		12/17/2018
	records room an e	observed that in the medical oxit sign was obstructed from upled center of the room. The ed by file cabinets.	*		will be installed by the engineering depart 12/17/2018 this findings will be monitore safety tracers and reported to the quality department on a monitry basis for work completion status by the engineering dej	tment on I during the managemer order	nt :
	room had items si	observed the kitchen storage tore to the height of the ceiling, uired 18 inch height clearance			please refer to: K 293 Plan of Correction ATTACHMENT # 17		

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	•	· ON	AB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING	<u></u>	08/03/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ontootzo (d
KEDREN		AL HEALTH CENTER	•	4211 SOUTH AVALON BLYD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies / Must be preceded by full sc identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
A 709	deflector and the to 10) The evaluator of wall across from ele	n of the sprinkler head p of storage. Observed that at the corridor Sevators 1 and 2, there was over plate at the wall mounted	A 701	A 709 Plan of Correction # 9 A of the items were removed on 07/31/2018 in keep the required 18° clearance, this findings monitored during the safety tracers and report quality management department on a monthly completion status by the engineering departm please refer to: K 351 Plan of Correction ATTACHMENT # 18	will be led to the basis for work order
	11) The evaluator of and hose cabinet to elevators 1 and 2 unlatches the cabin extinguisher and ho	bserved the fire extingulaher cated at the corridor wall next 2, was missing the handle that let door to access the fire		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 3
·	following conditions 1st Floor Children (12) The evaluator of	existed at the facility.		A 709 Plan of Correction # 11 A new handle was installed in the fire hose /F Extingulaher cabinet on 07/31/2-2018 Please refer to: K 355 Plan of Correction #2 ATTACHMENT # 20	ire
,	During an interview	at the same time as the rector of Facilities stated a		A 709 Plan of Correction # 12 New self luminous signs have been ordered a be installed on 11/30/2018 please refer to K 293 Plan of Correction please refer to; A 709 Plan of Correction # 8	11/30/2018 and wiji
		•		ATTACHMENT # 17	
٠ ,	caps were not place	observed eight of nine blow off ed on the nozzies of the n located above the cooking er:		A 709 Plan Of Corrections # 13 all of the blow off caps were put back 08/01/2 cleaning crew was in-serviced on 10/17/2018	
	During an interview	at the same time as the		hood cleaning and blow off cap replacement	
	observation, the Di	rector of Facilities		please refer to: K 324 Plan of Correction #1	•
	acknowledged the the nozzles.	caps needed to be placed on		ATTACHMENT # 21	

14) The evaluator observed one of one blow off

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		054083	B. WING	W-1-1-1-1		08/0	3/2018
	ROVIDER OR SUPPLIER	al Health Center		4:	TREET ADDRESS, CITY, STATE, ZIP CODE 211 SOUTH AVALON BLVD OS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of Deficiencies / Must be preceded by fult, sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(XS) COMPLETION DATE
A 709	suppression system area.	on the nozzle of the nozzle of the cooking	A	709	A 709 Plan of Correction # 14 The blow of was was put back on 08/31/2018 cleaning craw was in-serviced on 10/17/2018 hood cleaning and blow off cap replacement please refer to: K 324 Plan of Correction # 22	in proper	08/31/2018
	identified as Clinic	observed that in the room by a paper sign posted on the of six oxygen cylinder stored			A 709 Plan of Correction # 15 A new oxygen rack will be purchased and ins the engineering department on 11/20/2018		11/20/2018
	observation, the Di oxygen storage rac	at the same time as the rector of Facilities stated an ik would be obtained.			A TOD Man of Organitary & 40		11/20/2018
	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.			A 709 Plan of Correction # 16 A new oxygen rack will be purchased and in the Engineering department on 11/20/2018 an "Empty" "Full" sign will be installed on or rack		stalled by	
	observation, the Di acknowledged ther	e at the same time as the rector of Facilities e was no signage, and stated was not functioning.					•
	2nd Floor Administ	ration			•		
	room there was da by having a power extension cord that	observed in the conference isy chaining of extension cords strip that was connected to an in turn was connected to a that was connected to a wall receptacle.	• •		A 709 Plan of Correction # 17 Extension cords were removed by the engine department on 08/05/2018 A 709 Plan of Correction # 18 The fore penetrations in the server room and	i	08/05/2018
	Information Techno	observed that in the ology (IT) room there were			have been sealed with Fire reterdant material pleaser refer to; K 321 Plan of Correction # 4 ATTACHMENT # 23	ai i	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		054083	B. WING	de die nombre auch der der men der 15 <u>Ede Land ung der der Schricht d</u>	08/0	3/2018
	PROVIDER OR SUPPLIER I COMMUNITY MENT	al Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		D BE	(X5) COMPLETION DATE
A709		er room and one 1 inch by 2 the IT office.	A :	709		
	wall above the dou and the children ho During an interview	observed the smoke barrier ible doors between the elevator ospital had two penetrations.		A 709 Plan of Correction # 19 The fire penetration above the double doors elevator and children in patient unit has beer with fire retardant material on 08/01/2018 please refer to: K 372 Plan of Correction # 3		08/01/2018
:	observation, the Di acknowledged the 2nd floor Children	penetration.		ATTACHMENT # 24		and some them 4.44
	room 212 failed to During an interview observation, the Di	observed the corridor door of hold closed when shut. wat the same time as the irector of Facilities stated the closed because the strike plate		A 709 Plan of Correction # 20 The door in room 222 has been adjusted 08/02/1018 in order to have positive tatch please refer to: K 363 Plan of Correction # ATTACHMENT # 25	ng	08/02/2018
		observed a wall was wood in non-sprinklered room		A 709 Plan of Correction # 21 all of the existing plywood will be removed will be repaired to their original condition by please refer to: K 163 Plan of Corrections ATTACHMENT # 26		
Andreas and the state of the st	22) The evaluator down fire door that station from the chiabel on or around testing of the door. During an interview observation, the D	observed there was a drop t would separate a nurses narting room. There was no the door of inspection and . w at the same time as the director of Facilities stated there record of the door's current		A 709 Plan of Correction# 22 The drop down doors label was cleaned o 09/17/ 2018 and is visible now the drop do have been tested, inspected, and passed on 08/09/2018, please refer to: K 300 Plan of Correction # 1 and # 2 ATTACHMENT # 27	wn doors	08/09/2018

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		054083	B. WING	AMERICAN AND AND AND AND AND AND AND AND AND A	08/03	3/2018
, , , , , , , , , , , , , , , , , , ,	ROVIDER OR SUPPLIER COMMUNITY MENT	al Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFII TAG			(X5) COMPLETION DATE
A 709	Continued From pa	age 88	Α7	709		
		eview there was no nce presented of the door d tested.		A 709 Plan of Correction # 23		·
		observed a wall was rood in non-sprinklered room		Please refer to: A 709 Plan of Correction	‡21	
	observation, the Di	or at the same time as the rector of Facilities stated that blaced by plywood because the drywall.				,
,		observed a wall was vood in non-sprinklered room	,	A 709 Plan of Correction # 24 Please refer to: A 709 Plan of Correction	# 21 -	
	25) The evaluator room 345 was mis	observed the corridor door of sing.		A 709 Plan of Correction # 25 A new door was installed in room 345 on 09/17/2018, please refer to K 363 Plan of	the week of	09/17/2018
	observation, the Di the door was remo	vat the same time as the rector of Facilities stated that ved about one week ago ken and that they were waiting it door.		#4 ATTACHMENT # 28		
	room 347, a treatm	observed the corridor door of nent room, was a Dutch door stragal where the top and at.		A 709 Plan of Correction #26 A new metal astragal was installed on 08/ Please refer to: K 363 Plan of Correction ATTACHMENT # 29	01/2018	08/01/2018
	above the cross co had a 1 Inch diame	•		A 709 Plan of Correction # 27 Fire penetration across Room 348 has be with fore retardant material on 08/01/2016 Plans refer to: K 372 Plan of Correction	en sealed	08/01/2018
	During an interview observation, the Dithe wall as a fire but	v at the same time as the rector of Facilities identified arrier wall.		ATTACHMENT # 30		

PRINTED: 10/10/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XX) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 054083 08/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD KEDREN COMMUNITY MENTAL HEALTH CENTER LOS ANGELES, CA 90011 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) PLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY A 709 Continued From page 89 A 709 28) The evaluator observed there was a drop A 709 Plan of Correction # 28 down fire door that would separate nurses station Please refer to: A 709 Plan of Correction # 27 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. 29) The evaluator observed there was a drop A 709 Plan of Correction # 29 down fire door that would separate nurses station Please refer to: A 709 Plan of Correction # 27 one from the day room. The fire rating plate on the door was painted over and illegible. 30) The evaluator observed the corridor door of 09/17/2018 A 709 Plan of Correction # 30 room 352 failed to hold closed when shut. A new door was installed on room 352 on the week of 09/17/2018 During an interview at the same time as the Please refer to: K 383 Plan of Correction # 2 observation, the Director of Facilities stated that ATTACHMENT #31 the door falled to hold because the wrong type of strike plate was installed. 3rd floor Adult In Patient (AIP 2) 08/01/2018 A.709 Plan of Correction #31 31) The evaluator observed the smoke barrier

could see the penetration.

penetration.

wall above the ceiling separating the corridor from

room 325, an office, had a 1 inch diameter

. During an interview at the same time as the

observation, the Director of Facilities stated he

ATTACHMENT # 32

#2

The fire penetration above calling separating the

corridor from room 325 has been sealed with fire

retardant material by the engineering department on

08/01/2018 please refer to K 372 Plan of Correction

PRINTED: 10/10/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 054083 8. WING 08/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4211 SOUTH AVALON BLVD** KEDREN COMMUNITY MENTAL HEALTH CENTER LOS ANGELES, CA 90011 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID PREFIX (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 709 Continued From page 90 A 709 3rd floor Adult Out Patient (AOP) 10/26/2018 32) The evaluator observed that in doctor office 8 A 709 Plan of Correction # 32 there was daisy chaining of extension cords by Extension cords will be removed for Dr's office # 8 by the engineering department on 10/28/2018 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 10/26/2018 A 709 Plan of Correction # 33 worker office there was an extension cord that Extension cord will be removed from the social was passed under the carpet across a threshold worker office by the engineering department on that was connected to a wall mounted electrical 10/28/2018 receptacle. **Document Review** A 709 Plan of Correction #34 09/19/2018 Smoke detector sensitivity testing was conducted on On 8/2/18 at 9:50 a.m., document review 09/19/2018 revealed the following: Please refer to:K 345 Plan of Correction ATTACHMENT # 33 34) Document review by the evaluator revealed there was no documented evidence of sensitivity A 709 Plan of Correction #35 10/17/2018 of the smoke detectors. A new emergency generalor/transfer switch test log 35) Document review by the evaluator revealed that includes generator testing, transfer switch testing, 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.

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			,	FORM APPROVEL 2MB NO. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING			08/03/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	1 0010012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
A 709	Continued From pa	ge 91	Α7	709)	
	document review, that the transfer timeseconds but that the being documented on the log to document.	at the same time as the he Director of Facilities stated e was between 8 to 10 e transfer times were not because there was no place hent the times, and that the log to include a place to enter				
	there was no docun regulations were ad including smoking p smoking areas, while smoke, which paties supervision of paties ashtrays of noncom design in all areas v and providing metal cover devices into v	w by the evaluator revealed nented evidence that smoking opted for smoking by patients, prohibited areas, designated ch patients are prohibited to nte are allowed to smoke, nts smoking, providing bustible material and safe where smoking is permitted, containers with self-closing which ashtrays can be emptied all areas where smoking is				
	and Procedure, nun revised date of 3/1/3 purpose of the polic for governing a smo and that the scope of	ke Free Environment Policy obered 7080.7577.53 with a 2008, indicated that the y was to provide guidelines oke free work environment, of the policy was applicable to policy had no indications in it ents.	·			
A 724	document review, th	at the same time as the ne Director of Facilities stated smoking by patients at the c. LIES, EQUIPMENT	Α7	⁷ 24		,

CENTER	12 LOW MEDICALE	A MEDICAID SERVICES				ילאו פועני.	1960-0680
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PPLIER/CLIA IN NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				BURVEY PLETED
		084083	B. WING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ere <u>Carage and a second of the Carage and the Cara</u>	08/0	3/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		4211	eet address, city, state, zip code I south avalon blyd 3 angeles, ca 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of Depiciencies / Must be preceded by full sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETION DATE
A 724	MAINTENANCE CFR(s): 482.41(c)(fracilities, supplies, maintained to ensu safety and quality. This STANDARD is Based on observationspital failed to enequipment were maintain equipmen by not maintaining light shields; failed working in the hand the medication storingation that mursing urwas no white miner room in the Adult in The deficiencies hapractice of infection any person that maintaining of the eyes temperature, and form lighting tubes	~		724			
	Findings:						40/00/0040
	starting at 11:10 AM surveyor found the uncomfortably warr warning of the high 1, 2018 at 10:20 AM water temperature	f the kitchen on July 31, 2018. I, during hand washing, the water temperature to be in. There was no signage water temperature. On August I during hand washing, the cince again felt uncomfortably with the DFS on August 1, bout the high water		A in de th	724 Plan of Correction # 1 lease refer to: A 701 Plan of Correction # new faucet mount eye wash station will the kitchen hand washing sink by the enspartment on 10/26/2018 is A 724 section findings will be monitore a safety tracers and reported to the qualitanagement department on a monthly bas der completion status by the engineering	e installed gineering d during y Is for work	10/28/2018

PRINTED: 10/10/2018

	& MEDICAID SERVICES			_		OMB NO	MAPPROVED 0.0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		ONSTRUCTION		(X3) D/	ATE SURVEY OMPLETED
		054083	B. WING			٠,		0/02/2040
	PROVIDER OR SUPPLIER I COMMUNITY MENTA	AL HEALTH CENTER		4211	ET ADDRESS, CITY, S SOUTH AVALON BL ANGELES, CA 90	.VD	<u> </u>	8/03/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Viewent of Deficiencies Y Must se preceded by Full SC (Dentifying (Nformation)	ID PREFI TAG		(EACH CORRECT) CROSS-REFERENC	LAN OF CORREIVE ACTION SKI ED TO THE APP FICIENCY)	OH IN BE	(XI) COMPLETION DATE
A724	temperature, DFS at the water temperature acknowledged the acknowledged the acknowledged the senough (20 second stated one of the rerequested that wate and so it was turned department. A temperature check 126.1 degrees Fahr more effective than fatty soils encounter flow of warm water aid in flushing soil of water temperature to uncomfortable may practices by food er 2017. Food Code Schandwashing sink is water at a temperat through a mixing var ASTM Standards for handwashing formultemperature of 100 for Testing and Materinational standard and publishes volum standards for a wide systems, and service Also attached to the station. Higher water the eyes and can er with the skin and ey Standards Institute Safety Equipment A	stated he was not aware that ure was high and water temperature would not staff to wash their hands long is) as recommended. The DFS egistered distitlans (RD 1) had er temperature be increased drup by the facilities. Ck of the water showed it as renheit (F). Warm water is cold water in removing the red in kitchens. An adequate will cause soap to lather and culckly from the hands. High that makes hand washing read to poor handwashing mployees. According to the ection 5-202.12 (A) "A shall be equipped to provide ture of least 100 degrees Faive or combination faucet". For testing the efficacy of utations specify a water to 108°F. American Society tends (ASTM), is an arrived surface of materials, products, ces. The American National (ANSI) and the International Association (ISEA) developed	A7	'24				
	the American Nation	nal Standard for Emergency	•				-	

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WEIN FI	703 1 (N.1.) 141((1)(N.1.)(1)(T)	O MENDO APIZATA			
STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COMPLETED
		054083	B. WING		08/03/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE COMPLETION
A 724	Eyewash and show the use, installation for emergency eye (ANSI/ISEA z358.1-requirements for in emergency eye was wash station head for 15 minutes". Ac z358.1-2014, "teplo temperature condu 16-minute irrigation to 100 degrees Faltemperatures are henhance chemical eyes. The tapid wa compliance with the 2. At 2:15 PM on Ji 2-compartment sin sanitizing compartrictipping of the hot potential to dilute the making it ineffective equipment and ute	rege 94 ver Equipment standards for operation and maintenance wash and shower equipment -2014). ANSI/ISEA staliation for plumbed sh station include the eye "deliver, tepid flushing water cording to ANSI/ISEA d" is defined as a flushing fluid licive to promoting a minimum operiod. A suitable range is 60 hrenhelt." Higher water laarmful to the eyes and can interaction with the skin and ter is also to encourage e 15-minute irrigation period. Luly 31, 2018, the faucet in the k was leaking hot water in the ment water. The constant water into the solution had the ne concentration, thereby e. Sanitization of food service insils removes (kills) potential ganisms on the surface of the	A	A 724 Plan of Correction # 2 A new faucet was installed in the kitchen or sink by the engineering department on 08/0 ATTACHMENT # 35	
	The facilities mana during the observa- but would repair the Observation on Au	iger (FM) who was present tion, stated he was unaware e faucet by the next day. gust 3, 2108 at 2:50 PM, had not been repaired.			
	gauge for the dish glass on the dial wa temperature was s	ugust 1, 2018, the temperature machine was broken. The as cracked, chipped and tuck at 140 degrees F for both ecoles. The FSM flicked the		A 724 Plan of Correction #3 A new temperature gauge was installed by washer Vendor the on 08/08/2018 ATTACHMENT #38	08/08/20 dish

temperature gauge with her finger, which moved

		G WEDICAID SERVICES	,		OMB NO. 0938-0391		
STATEMENT AND FLAN C	ENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING.			(X8) DATE SURVEY COMPLETED			
		054083	B. WING	<u> </u>	00/02/0040		
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	08/03/2018		
KENBEN	COMMUNITY MENTA	U LEATTH GEATER	ŀ	4211 SOUTH AVALON BLVD			
116DITEN	COMMUNITY INCH!	al reality center	ł	LOS ANGELES, CA 90011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of deficiencies Must be preceded by full BC identifying information)	(D PREFI) TAG	Provider's Plan of Correct ((Each Corrective action sho) Cross-referenced to the appr Deficiency)	JLD BE COMPLETION		
A724	temperature gauge wash cycles were o recommended mini	ge 95 om 140 to 108 degrees F. The did not move after several bserved. The manufacturer's mum water temperature for h wash and rinse cycles was	A7	24			
, .	machine stated the is checked using a The temperatures a and listening to the stated in a concurrence remember how broken and when it inserting a food the check water temperature and increase due an increase.	er (FSW 3) who operated the water temperature of machine hand-held food thermometer, are recorded while watching different cycles. The FSM ent observation that she could long the thermometer had be food service staff started mometer in the water well to ratures. The process was eased the risk of burn as the transfer was flowing and circulating					
	faucet in the chemic outside the kitchen. two paired hose bib red and black in col "threaded faucet als The end of the red in the floor with a dibubbles resembling connection did not it back-flow prevention significant build-up on the rack adjacer rust. There was a sithe horizontal brack keep the faucet in g	spewing out leaking from the cal storage/janitorial area Attached to the faucet was a connection, the hoses were or. A hose bib(b) is a so known as a wall hydrant". hose was inside a blue bucket ark brown solution, with soap or detergent. The nave an anti-siphon or n device. There was a of a brown colored substance at to the faucet, resembling imilar colored substance on set that held the water pipe to slace. The presence of rust on of the presence continued in		A 724 Pian of Correction # 4 A new faucet was installed in the janitoria the engineering department on 08/08/201 device will be installed on11/23/2018 ATTACHMENT # 37			

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	0.10VA			0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E ' -	TIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		054083	B. WING	**************************************	08/	03/2018
	PROVIDER OR SUPPLIER I COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
A 724	Continued From pa	17 Food Code Section	Α7	24		
,	5-203.14. "a plumbi preclude backflow contaminant into the point of use at the final and a hose bibb if a libackflow prevention providing an air gap	ing system shall be installed to of a solid, liquid, or gas a water supply system at each cod establishment, including hose is attached and of its required by law, by: (a) as specified under § alling an approved backflow				•
	2018 starting at 3:5: aware of the leaking with the FSD on Au PM, the FSD indica facilities departmen that needed repairs were in form of ema	or in an interview on August 1, 0 PM indicated he was not g of the faucet. In an interview gust 1, 2018 starting at 4: 00 ted he made reports to the t about the various equipment. The FSD stated the reports all but was unable to provide orts because he "does not				•
* tr	room had broken. T	ral light fixtures in the dish his could be a source of n of the clean dishes stored in		A 724 Plan of Correction # 5 Broken light fixtures have been replaced by engineering department on 08/08/2018 ATTACHMENT # 38	/ the	08/08/2018
	shielded, coated, or areas where there is	"light bulbs shall be otherwise shatter-resistant in exposed food; clean and linens; or unwrapped ingle-use articles".		A new eye wash station inspection log has implemented on 10/17/2018 and will be make engineering department on a waskiy to will be reported to the safety committee as monthly QAPI report. All faulty eye wash be replaced on 10/28/2018	onllored by asis and it part of the	
	that in the boiler roo	a.m., the evaluator observed m located in the basement, nented evidence of testing of		ATTACHMENT#39		

PRINTED: 10/10/2018

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Ol		APPROVED 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		054083	B. WING	·		00/	∆\$!0040
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	81	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/2018
KEDREN	COMMUNITY MENTA			42	211 SOUTH AVALON BLYD OS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
A 724	the eyewash station observation the Dire operating the pull kin station. At first on a sides of the eyewas and struggling with Facility was able to flow from the nozzle During an interview observation, the Director observation, the Director observation, the Director observation, the Director observation of the eyewash of the eyewash station in the kitches facilities activated the eyewash station.	n. During the same ector of Facilities had difficulty nob to activate the eyewash trickle of water ran down the sh nozzles, then after a delay the pull knob the Director of pull the knob to activate water as of the eyewash station. at the same time as the ector of Facilities bull knob was stuck, and wash was supposed to be that it had not been tested. 8:30 a.m., and 2:30 p.m. the existed in the facility.	, A7		A 724 Plan of Correction # 6 A new eye wash station inspection log has be implemented on 10/17/2018 and will be montithe engineering department on a weekly basiwill be reported to the safety committee as parenthly QAPI report ATTACHMENT # 39	ilored by is and it	10/17/2018
	person activating the Closer observation was controlled by a	e eyewash. revealed the water source single sensor valve and not d cold water valves. At this	•				:
	time the temperatur a result of 120 oF (c	e of the water was tested with degrees Fahrenheit).					i
	observation, the Dir acknowledged the f wrong direction, the	at the same time as the ector of Facilities low of the water was in the at the water temperature was that there was no testing of		t			

77-17-1		- M MERIWAIN DEIMINED	***************************************			<u>, </u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		re survey MPLETED
		054083	B. WING	Marie And Annual Control of the Cont	08/	/03/2018
KEDREN	PROVIDER OR SUPPLIER N COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011		Technological Control
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	IO PREFID TAG		JLD BE	(X5) COMPLETION DATE
A 724	the eyewash, that it because the water eyewash would repire. The evaluator obfixtures in the food had cracked diffuse inch section was midiffusers/covers.	the eyewash would be removed was too hot, and that a bottle blace it. Deserved two of six ceiling light preparation and cooking area ars/covers, and a 6 inch by 2 dissing from one of the	Α7	A 724 Plan of Correction # 7 All the cracked diffusers and covers have replaced and shielded on the food prepar cooking area on 08/08/2018 ATTACHMENT # 40		08/08/2018
	stated that ceiling lig replaced 8. The evaluator ob- fixtures in the dishw diffusers/covers exp	the Director of Facilities ight fixtures were going to be served three of six ceiling light vashing area were missing posing the glass tubes. No shields were observed at the		A 724 Plan of Correction #8 All the cracked celling light fixtures in the area have been replaced on 08/08/2018 engineering department ATTACHMENT #41		08/06/2018 09
	was missing in the runit at the kitchen d. 10. On 8/1/2018 at a inspection of the me room) at the CIP, the the entrance of the attempted to turn the faucet produced a til maximum turn. The	served one of two light shields reach in refrigerator freezer lry storage area. around 4:10 p.m. during an edication storage area (med here was a sink to the right of med room. The surveyor he faucets on; however, the liny stream of water at a director of pharmacy (DOP) faucet was not functioning		A 724 Plan of Correction # 9 Missing light shield in the refrigerator free replaced by the engineering department of A 724 Plan of Correction # 10 A new faucet will be installed on 11/08/20 Medication room at the CIP Unit	n 11/16/201	11/16/2018 8 11/08/2018
	nurse indicated the sinks located elsewinknown amount of 11. During a tour of	t interview, the unit charge nurses had been using other here in the unit for an f time. the facility's medication room 00 AM on the Adult InPatient		•		

		& WIEDICAID SERVICES			OMB NO. 0938-0391
AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	V(S) WAL	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		054083	B. WING	,	08/03/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD	0000002010
434.00.000	0110010010010010			LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE CONPLETION
A 724	Continued From pa			24 A 724 Plan of Correction # 11	11/08/2018
	area 1 (AIP1), the fa	aucet appeared to have white the end of the appear	A f	A new faucet will be installed on 11/08/20 medication Room	18 in the AIP
	there was no hot wa	arge Nurse acknowledged ater available from this faucet opear crusted with some kind		•	
A 726	VENTILATION, LIG CONTROLS CFR(s): 482.41(c)(4	HT, TEMPERATURE I)	A7.	26	
	temperature control preparation, and off This STANDARD is Based on observat review, the hospital temperature monito medication storage as medication room	er ventilation, light, and is in pharmaceutical, food her appropriate areas. In not met as evidenced by: ion, interview, and record failed to ensure there were and devices installed in the and preparation areas, such is at the nursing units; and ilighting fixtures in the kitchen			
		ce had a potential affecting y, and/or potency of the			<i>.</i>
	Findings:				
	inside the adult inpa 7/31/2018 at 12:55 (DOP) confirmed th monitoring device for During an interview	tion of the medication room tient station 1 (AIP-1) on p.m., the director of pharmacy ere was no temperature or the ambient temperature. on 8/1/2018 at 11:16 a.m., the focumented daily monitoring		A 726 Plan of Correction # 1 A new temperature monitoring device will by the engineering department in the mot rooms on 11/26/2018 this A 726 findings monitored during the safety tracers and not the quality management department on a monitry basis for work of completion status by the engineering department	lication will be , eported to order

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WING)		08/03	3/2018
	PROVIDER OR SUPPLIER COMMUNITY MENTA	AL HEALTH CENTER		421	REET ADDRESS, CITY, STATE, ZIP CODE I1 SOUTH AVALON BLVD IS ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies / Must be preceded by full sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X6) COMPLETION DATE
A 726	storage areas locat were four such area pharmacy.	ge 100 perature inside the medication ed at the nursing units; there as excluding the inpatient ital policy and procedure.	A	726	·		
	Temperatures: Stor indicated all drugs to temperatures that de-	age, last reviewed 4/2018, shall be stored at appropriate to not exceed manufacturer's ne policy also indicated a		•			
	Storage of Medicati indicated "Drugs sh	nospital policy and procedure, ons, last reviewed 4/2018, all be stored under the proper tion, temperature, light, 1,"		,		,	
,	b. On 8/1/18 between following conditions	en 8:30 a.m. and 2:30 p.m. the existed in the facility.	ý	1	A 726 Plan of Correction # 1 new temperature monitoring devices will be i on 11/20/2018 in all the pharmacy rooms		11/20/2018
	3rd floor Pharmacy	; 35:			on Trzozo16 iii ali ula phaniacy iodina		
,	rooms, including the Patient (AIP) 1 and there were tube typ thermometers with	served that in medication e medication rooms at Adult In Children in Patient (CIP), e refrigerator/freezer a -18 to 84 oF (degrees n use to measure the ambient rooms.					•
	there was a dial typ	rved that in the Pharmacy e refrigerator thermometer range in use to measure e of the room.		* * *		,	
	The evaluator's revi number 8390.09.04 storage revised 10/2	ew of policy and procedure for pharmacy temperature 2014 defined room					

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		& MEDICAID SERVICES		·	MB NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054063	B. WING		08/03/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2016
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER	1	4211 SOUTH AVALON BLVD	
***************************************				LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
A 726	Continued From pa	ne 101	A7	ne	
		ontrolled room temperature as	M C	20	
	a temperature held	between 69 and 86 oF.		•	
ı		easuring instruments used to			
	medication mome :	and the pharmacy did not have			
	the range necessar	y to determine if the ambient			
,	room temperature v	was out of range.		·	
	Perdan ne Intominu	and the manuscript and the same			
	observations the D	at the same time as the virector of Facilities stated that			
	the ambient temper	ratures of the medication			
	storage rooms are i	monitored daily by use of a			;
	laser temperature g	un and recorded in the			
	temperature log.				
•	On 8/2/18 at 11:09	a.m., the evaluator's review of		A 726 Plan of Correction # 3	09/01/2018
	the weekly tempera	iture log book revealed that		A new temperature Log to include the medic	ntion
		eratures were monitored		rooms was implemented on September 201	
	weekly not daily, an	id that the temperatures were different and 2 patient		has been monitored and recorded by the ph	armacy
	rooms and (nurses)	stations' 1 and 2. There was		department on a daily basis ATTACHMENT # 42	
	no documentation to	hat temperatures were		NI INDITIMENT IF 4E	
	monitored at the 2n	d floor CIP including the CIP			
	medication room ar Outpatient.	nd the Pharmacy at 3rd floor	•	·	
•	Outpatient.				
	1st floor kitchen				
	2) The evaluator ob	served that one of six ceiling		A 726 Plan of Correction #4	08/03/2018
•		dishwashing area was not		Burned light bulbs in the dish washing are v	
:	providing light.	₩ •		replaced by the origineering department on ATTACHMENT #43	08/03/2018
	3) The evaluator ob	served one of six ceiling light		A 700 Pierra of Commention of S	Animomes a
	fixtures in the food	preparation and cooking area		A 726 Plan of Correction # 5 The burned light bulbs in the food preparation	08/03/2018
	was not providing lig	aht.		were replaced by the engineering departme	
	4) The evaluator of	served there was no light in		08/03/2018	,
		ator freezer at the kitchen dry		ATTACHMENT # 44	

CENTER	(8 PUR MEDICARE	: & MEDICAID SERVICES				110.	<u> </u>
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(XS) DATE SURVEY COMPLETED	
		0540B3	B. WING			08/0	3/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KENDEN	COMMINITY MENT	AL HEALTH CENTER		•	11 SOUTH AVALON BLVD		
KEUKEN	COMMUNIT MENT	al realin center		LC	S ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)) D E	COMPLETION DATE
A 726		er observation revealed one of missing and one of two light	Α:	726	A 726 Pian of Correction # 6 The burned and missing light bulbs in the refrigerator in the dry storage room have to replaced on 08/03/2018 by the engineering ATTACHMENT # 45	een	08/03/2018 ant
A747	observation, the Di bulbs would be rep		A	747	•		
	to avoid sources at and communicable active program for	provide a sanitary environment nd transmission of infections diseases. There must be an the prevention, control, and ections and communicable					
	Bases on observa review the hospital	is not met as evidenced by: tion, interview and record did not meet the Condition of ection control by failing to:					
,		diffied infection control officer nce, training, education, or r to A 0748)			The CQI Director currently has a hiring a full-time infection Control Preventionist interviews will be conducted once qualific have been received. In the interim the CQ	(RN). id applican ⊇i Coordina	11/7/2018 [*] ts
	failed to monitor the over-produced time (TCS) food Items (food). The facility to ensure food was	m to prevent infections when it to cooling of several leftover or a temperature control for safety formerly potentially hazardous did not have a system in place a cooled to the appropriate the recommended or to A 749)		:	LVN is acting in that capacity and has he training in Infection Control Courses such importance of Surface Distribution and Distribution and Distribution and Distribution Control to the two day LADPH Infection Control training the Infection Control Courses and Infection Course and Inf	i as Th o epaitment vill attend	a)
	3. Monitor tempera document the proc	atures or utilize a cooling log to ess. (Refer to A 749)		. :			•

DEPARTMENT OF HEALTH AND HIS

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	OMB NO. 0938-039- (XS) DATE SURVEY COMPLETED
		054083	B. WING _		00/20/20
name of	PROVIDER OR SUPPLIER		' 	STREET ADDRESS, CITY, STATE, ZIP CODE	08/03/2018
	N COMMUNITY MENTA			4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II TO RE COMOLETIAN
A 747	4. Ensure the direct operation meet stat for the job including course for manager employees had concontrary to state law	age 103 tor of the food service te educational requirements p completion of a food safety rs. Only two of the ten npleted a food safety course w that requires all food service a food handler's course.	A74	7	
	5. Provide a hospita (Refer to A 749)	ni wide infection control plan.		5. The Annual Infection Control (IC) Plan wand signed on October 8, 2018. (Attachme	ras updated 10/8/2018 ent W).
	patients, by failing to machine that check blood stream) was o	nd sanitary environment for o ensure the glucometer (a s the amount of sugar in the disinfected according to ructions. (Refer to A 749)		In-service will be held during change of pre/post test. Glucometers will be cleaned to MFU before and after each use. Nurse twill use audit too! weekly and monitor the beignature and date daily. The DON will be	In accordance Supervisor og for
A 748	resulted in the facilit effective hospital with	ct of these systemic problems by's inability to provide an de infection control program ading to increase probability of ROL OFFICER(S)	A748	of deficiencies. Evidence of compliance we monitored by CQI on a monthly basis via transfer reported to the QAPI and Risk Mana Committee; IC, MEC; and Governing Board	vii) be recers gement d.
	CFR(s): 482.42(a) A person or persons infection control offic	s must be designated as cer or officers to develop and governing control of infections		The CQI Director currently has a hining act a full-time infection Control Proventionist (F interviews will be conducted once qualified have been received. In the interim the CQI LVN is acting in that capacity and has had training in infection Control Courses such a	RN). 11/7/2018 spplicents Coordinator, coline
	Based on interview falled to designate a	not met as evidenced by: and record review, the facility qualified infection control by experience, training, ation.		Importance of Surface Disinfection and Del Housekeeping" completed 8/27/18 and will the two day LADPH Infection Control train! November 6-7, 2018.	partmental attend

November 6-7, 2018.

CENTE	OMB NO. 0938-0391				
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		054083	B. WING	WANTED TO THE TOTAL PROPERTY OF THE TOTAL PR	08/03/2018
NAME OF	PROVIDER OR SUPPLIER	*		STREET ADDRESS, CITY, STATE, ZIP CODE	1 000072010
KEDREN	COMMUNITY MENTA			4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFIDIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIEMING)	DIRE COMPLETION
A 748	11:20 AM, he stated Vocational Nurse (II) working at this facilithe affirmed he preva case manager. He of this date he had a possess any training asked about the facility was currengarding influenza stated the facility was stated.	on with ICO on 7/31/2018 at I that he was a Licensed VN) who had only been ty for approximately 6 months; lously worked at this facility as a continued on to say that as not received any training or a in infection control. When	A 74	The CQI Director currently has a hiring act a full-time infection Control Preventionist (I interviews will be conducted once qualified have been received. In the interim the CQI LVN is acting in that capacity and has had training in infection Control Courses such a temportance of Surface Disinfection and De Housekeeping" completed 8/27/18 and will the two day LADPH Infection Control train November 6-7, 2018.	RN). 11/7/2018 I applicants Coordinator, online as The partmental If attend
	evidence of training INFECTION CONTR CFR(s): 482.42(a)(1) The infection contro develop a system fo investigating, and communicable disease personnel. This STANDARD is Based on observation documents, manufaction interviews, the hospito prevent infections	ROL PROGRAM) I officer or officers must r identifying, reporting, ontrolling infections and ases of patients and not met as evidenced by: on, review of facility cturer's instructions and staff tal falled to develop a system when it falled to monitor the	A74	The CGI Director currently has a hiring act a full-time infection Control Preventionist (interviews will be conducted once qualified have been received. In the interim the CGI LVN is acting in that capacity and has had training in infection Control Courses such a importance of Surface Disinfection and De Housekeeping* completed 8/27/18 and withe two day LADPH infection Control train November 6-7, 2018. The online training or are currently located in the HR personnel file.	RN). 11/7/2018 I applicants Coordinator, online as The partmental II attend ing on ertifications
	cooling of several let temperature control	tover or over-produced time for safety (TCS) food items			

STATEMEN	T OF DEFICIENCIES	Taxa analina de la viole de la	7		<u>OMB NO. 0938-0391</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
MARCAC	PROVIDER OR SUPPLIER	064083	8. WING		08/03/2018
I IMME OF	MOVINER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	
KEDRE	OMMUNITY MENT	AL HEALTH CENTER	1	4211 SOUTH AVALON BLVD	:
		THE THE PERSON OF THE PERSON O	- 1	LOS ANGELES, CA 90011	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECT	Irski
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	X (EACH CORRECTIVE ACTION SHOU	ILD BE COMBIÉTION
,,,,		no menti tino ili otimpi lotti	TAG	CROSS-REFERENCED TO THE APPRODE	OPRIATE DATE
***************************************			**************************************		***************************************
A 749	Continued From pa	as 40E			
,,,,,			'A7	49	
	(romeny potentially	hazardous food). The food			
	items including nce	, chicken salad, gravy,			
	pulatues and peans	had been stored in the			
	many as 10 days. T	out twenty- four hours to as			
,	in which the food w	he size of the food containers are stored varied from as little			<i>'</i>
	as a few convince to	a large 6- quart container			
	(about 8 Inches tall)	of cooked Spanish rice filled			
	all the way to the hi	im. The facility did not have a			
	system in place to e	insure food was cooled to the			
	appropriate tempera	sture within the recommended			
	time-frames. The Fo	ood Code provision for cooling			
	"The food danger zo	one refers to temperatures			
	above 41 degrees F	and below 135 degrees F			
	that allow the rapid	growth of disease causing			
	microorganisms tha	t can cause foodborne illness			
	Foods held in the da	anger zone for more than			
	6 hoursmay c	ause a foodborne illness if			
	consumed". (Center	's for Medicare and Medicaid.			
	State Operations Ma	anual)			
	Meet dr tita dt. d				
	The facility did not n	nonitor temperatures or utilize		In accordance assessment of an interest and a second	
	a cooling log to doci	ment the process. The		In-service was provided to kitchen staff or	
	director of Food sen	vice (DFS) responded to the		August 3, 2018, Pre/post test was also gi	/en to
	surveyor on //31/18	at 11:46 AM about the lack of		assess competency. (Attachment X).	
	Thomloring or lettove	ir items. The staff falled to			ļ
	but not limited to die	corrective actions including carding the Items and		•	
	Angurian tamparatu	e monitoring was taking			1
	place More laffour	or over-produced items were			
	found in the refringer	ator the following day on			I
	August 1, 2018 at 10	3:25 am. In addition, on			l
	August 1, 2018 at 11	:30 AM, staff reheated a			
	leftover chicken diah	from the day before that was			. 1
	not monitored for no	oper cooling and attempted to .			
*	serve to staff in the	cafeteria before the surveyor			ł
	stopped it from being	d served.		,	ļ
	Bolto or no am an abrea of smithers !	g जिल्हारकार		•	-
	The director of the fo	ood service operation did not			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES				<u> NO BINC</u>), 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		ONSTRUCTION		TE SURVEY MPLETED
		054083	B. WING	·	THE ATTENDED WHITE HARMAGE REPORT TO THE ATTENDED ATTENDE	08	/03/2018
NAME OF I	PROVIDER OR SUPPLIER			STRE	SET ADDRESS, CITY, STATE, ZIP CODE		Market Keeks
KEDREN	COMMUNITY MENTA	AL HEALTH CENTER		4211	SOUTH AVALON BLVD		
			eran ar hadan ar hadan ar h	ros	ANGELES, CA 90011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 749	Continued From pa meet state education including completion managers. Only two completed a food a law that requires all complete a food has service manager which was a food has safety course for m who had a food har employees who were the failure of the home corrective action on had been identified immediate jeopardy potential to result in the potential to cause death to all 33 paties immediate jeopardy 2:20 PM. The surve nursing officer of the situation. On 08/2/1 nursing officer provinction. The actions jeopardy situation in items, educating statems after all meals and staff training on growth.	ge 106 snal requirements for the job in of a food safety course for of the ten employees had afety course contrary to state i food service works to indier's course. The food ho had completed a food anagers and one of the cooks idler's card were the two re compliant. Dispital to monitor proper is of staff knowledge and int the process and the lack of it the part of the DFS after it the day before created an if (IJ) situation that had the food borne illness including ints and staff. If was declared on 08/2/18 at by team informed the chief is immediate jeopardy at 6:40 PM, the chief ided an acceptable plan of to remove the immediate included discarding any leftover aff on discarding all leftover are served without exception if food safety and bacterlai		749	DEFIGENCY)	ž	
-	amount, degree or i 3:05 PM when the fi	edge of proper cooling of food.	٠	:			, ;

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

PRINTED: 10/10/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

054083 B. WING

08/03/2018

KEDREN COMMUNITY MENTAL HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

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 107

NAME OF PROVIDER OR SUPPLIER

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 teltover items observed stored on the top shelf in the refrigerator. There was sally mashed potato dated 7/26/18, diced potato dated 7/12/18, beans dated

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

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	HENT OF DEPICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		054083	B. WINC		in the state of th	ÓB	1/03/2018
NAME	OF PROVIDER OR SUPPLIER		I	BTI	REET ADDRESS, CITY, STATE, ZIP CODE		
KED	REN COMMUNITY MENTA	AL HEALTH CENTER		ł	H SOUTH AVALON BLVD		
				l ro	8 Angeles, CA 90011		
(X4) PRE TA	X (EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	COMPLETION DATE
A	49 Continued From pa	no 100	٨	749			
'''		es dated 7/12/18, rice dated	- ^	140			
	7/29/18 another co	ntainer of rice dated 7/30,			••		
		3. The surveyor shared the BDFS. The DFS stated on					
	August 1, 2018 at 1	10:28 AM, the kitchen's priority					:
	was" to get breakfa	est and lunch out". DFS then					:
	Cook 1 stated in the	dispose of the leftover items. e concurrent interview and					:
	observation on Aug	just 1, 2018 at 10:29 AM, he					
	believed there was	a 3- day grace period to use					•
	logs.	hey do not monitor or use any					
	On August 1, 2018 stainless steel pan manager stated ite smothered chicken being reheated for the entrée for the dchicken which had was the substitute.	at 11: 35 AM, there was a in the oven. The Food Service m in the oven was the from the day before was the cafeteria. FSM explained ay was pork chop and the been stored in the refrigerator The FSM stated there was no toring of temperatures of the leted.					
	titled, "Receiving Fi 4/26/17 under the s over-produced food states "over produce on the steam table, For example, 10 ex wrapped, labeled, of cooking is complete foods must be used cooking time;".	pital policy and procedure cod and Supplies" dated subheading "Handling it, leftover food and extra food" and food which has not been may be stored for later use, thrap ortions of chicken may be lated and refrigerated, after ed. Over-produced refrigerated it within 48 hours of the original the hospital policy did not conitor cooling leftover or over		· · · · · · · · · · · · · · · · · · ·			

There were other deficient practices identified

PRINTEO: 10/10/2018

		& MEDICAID SERVICES			PORM APPROVED 0MB NO. 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		054083	B. WING		08/03/2018
	PROVIDER OR SUPPLIER N COMMUNITY MENTA	AL HEALTH CENTER	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 SOUTH AVALON BLVD LOS ANGELES, CA 80011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of deficiencies y must be preceded by full sc identifying information)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A 749	during the survey for improper food storage poor lee machine of uncleanliness of the and preparation of poisoning and food washing practices. 2. On July 31, 2018 boxes of colesiaw or refrigerator. All three use by date of 7/23 box of peas stored refrigerator dated 7 instructions to "Kee	ge 109 or both campus related to age, improper food cooling, leaning practices and general a foodservice area, storage food that could result in food bome illness, improper dish at 11;45 AM, there were three lated 7/3/18 stored in the e boxes had manufacturer's /18. There was also a 20 lb. on the lower shelf in the /20/18 with manufacturer's op frozen until ready to cook".	A 749	Contracted with Professional RD vendor - Nutricopia (Attachment M) to provide ment organization, Full time RD, and Director o monitor food service personnels' day to da activities and develop quality assurance pr (QAPI) Addressed in detail in staffing A81	Food Service to y ogram

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

4. During meal observation on August 1, 2018 at 12:10 PM the Adult in patient unit, Patient 38 had

- YE-11 1 E	TO LAW MEDICAKE	STATEDICATO SEKAICES			<u>OMB NO</u>	<u>. บยสน-บสยา</u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DAT	re Survey MPLETED
-	,	054083	B. WING		08	/03/2018
•	PROVIDER OR SUPPLIER COMMUNITY MENTA	al Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 80011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Y Must be preceded by Full BC Identifying Information)	(D PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOL CROSS-REPERENCED TO THE APPRI DEFICIENCY)	LDBE	(X5) COMPLETION DATE
A 749	asked for ice. The I (MHT) who supervi- was no ice available for ice stating "ice, ice getting louder. It container that held provided to Patient a potential source of	Mental Health Technician sed the patients stated there a. Patient 38 continued to ask ice, baby" with the request for MHT scooped ice from the the frozen dessert and 38. This ice could have been	Α7-	49		
	workers on August FSW explained that them with uniforms they need aprons it those themselves. I stated in an intervie PM, that he purchast takes it home to lau wearing an apron st 1, 2016 at 10:47 AM provide him with the plastic aprons melt stove and heating e present during the it was" between vend being provided with Services in an interview.	and the group or lood service 3, 2018 at 2:55 PM, a random the hospital does not provide and the expectation is that if new will have to purchase 5SW 3 who had an apron w on August 1, 2018 at 2:15 sed the apron he had and nder. Cook 2 who was also rated in an interview on August 1, that the hospital did not a pron. Cook 2 stated that the when he gets close to the quipment. The FSM who was nterview stated the hospital cors" and are currently not aprons. The Director of Fcod riew on August 3, 2018 at hospital does not provide		5. Hospital contracted with a new compan Uniform, to provide these services.	y, Republic	01/01/2019
	A review of the cont and current laundry that Contractor 1, (i kitchen towels, apro and pants as part of review of the contra provider) did not ind provided. There was	racts between the previous services provider, indicated previous provider) provided ins, chef's coat, cook shirts the service (Exhibit B). A ct for Contractor 2, (current icate if similar items were a a list of items as part of the ins or kitchen towels were on		Hospital contracted with a new company Uniform, to provide these services.	Republic	01/01/2019

PRINTED: 10/10/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	•		FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		054083	B. WING	***	00:00:00.00
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/03/2018
KEDREN	COMMUNITY MENTA			4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG		OULD BE COMPLETION
A 749	the list. In an intervisual supervisor (LS) on LS acknowledged to services did not protect the patients to possificate from clothing, diseases that are to Food employees will dirty clothing may could result in contable prepared. Food mathrough direct contable Code Annex) According to the 20 the following controlimplemented regard process used:	ew with the Laundry August 3, 2018 at 3:00 PM, hat the current laundry vide aprons. for food service staff exposed lible cross contamination of Dirty clothing may harbor ansmissible through food, no inadvertently touch their contaminate their hands. This amination of the food being y also be contaminated act with dirty clothing. (Food 17 Food Code Annex "All of I measures should be diess of the food preparation	. A 7		
	faucet in the chemic outside the kitchen. two paired hose bib red and black in col "threaded faucet als The end of the red i on the floor with a d bubbles resembling connection did not i back-flow preventio The lack of an anti-created a condition	spewing out leaking from the cal storage/janitorial area Attached to the faucet was a connection, the hoses were or. A hose bib(b) is a to known as a wall hydrant". The was inside a blue bucket ark brown solution, with soap or detergent. The nave an anti-siphon or n device, siphon or back flow device that could lead to the potential a hospital water supply with			

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		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	•	054083	B. WING	Distriction of the state of the	08/03/2018
	ROVIDER OR SUPPLIER COMMUNITY MENTA	IL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 SOUTH AVALON BLVD LOS ANGELES, CA 90011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
ei Teag	7. The hand washir located less than 6 the food preparatio splash- guard to prehands being washe prepared food on the splash of	ge 112 ated visibly dirty water in the g sink in the kitchen was inches from the drain board of n sink. There was no installed event soap or water from d from contaminating ne food preparation sink next	A 7	19	
	11:20 AM, he stated had an infection con been working at the When asked what he stated that he preports regarding p developed or report	ation with ICO 7/31/2018 at 1 he was not sure the facility atrol (IC) plan but he had only a facility for a few months. The duties up to this time were, imarily had been building atlent infectious diseases and during their stays. He dook for the IC plan which lity had.		8. The CQI Director currently has a hirling a full-time infection Control Preventions interviews will be conducted once qualified been received. In the interim the CLYN is acting in that capacity and has be training in infection Control Courses sufmortance of Surface Disinfection and Housekeeping" completed 8/27/18 and the two day LADPH infection Control to November 6-7, 2018.	st (RN). 11/7/2018 ified applicants CQI Coordinator, nad online ch as The Departmental I will attend
	end of the survey o 9. On 7/31/18 at 9:3 Adult Inpatient Unit how she cleans the sometimes cleans i On 7/31/18 at 10:40 glucometer is clean wipes.	35 a.m., during a tour of the (AIP) 2, Staff 8 was asked glucometer, she stated she twith alcohol wipes. 3 a.m., Staff 9 stated the ed using alcohol or Sani-Cloth		The Annual Infection Control (IC) Plan was and signed on October 8, 2018, (see alt	
	for cleaning the (Bri indicated the glucor	ne manufacturer's instructions and Name] Glucometer neter should be cleaned with isinfectant wipes, such as ermical Wipes and	·, •	•	

AND PLAN O	of Deficiencies F Correction	(X1) PROVIDER/SUPPLI IDENTIFICATION NU	er/Clia Imber:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE	0938-039 SURVEY PLETED	
		054083		B. WING	· ·			09/0	3/2018	
	ROVIDER OR SUPPLIER COMMUNITY MENT	AL HEALTH CENTER			4211	EET ADDRESS, CITY, STATE, ZIP I SOUTH AVALON BLYD 3 ANGELES, CA BD011	CODE		19120.19	
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	Continued From pa CaviWipes.	age 113		A 7	49					
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