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

08/27/2010
 APPROVED
 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2010
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NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 8/8/10 through 8/11/10. The facility was licensed for 16 beds. The census at the time of the survey was 15. The sample size was 8. Representing the California Department of Public Health: Kathleen Sullivan, Health Facilities Evaluator Nurse and Liliya Tushinski, Health Facilities Evaluator Nurse.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing activity program that met the needs of three of eight sampled residents (6, 3, and 5), and activity staff failed to provide documentation according to policies and procedures. Findings: 1. On 8/11/10, Resident 9's clinical record indicated his interests included exercise, sports, music, reading, trips, shopping, being outdoors, watching TV and movies in room, talking, and listening to the radio in his room. A review of Resident 9's activity progress notes dated	F 248	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH SEP 10 2010 L & C DIVISION SAN JOSE F248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES Requirements not met as evidenced by... the facility failed to provide an ongoing activity program that met the needs of three... residents, and activity staff failed to provide documentation... On September 8, 2010 the three residents were interviewed by the activities director and their care plans were updated. By September 25, 2010 the admission screening and ongoing needs assessment and documentation tools will be reviewed and revised as needed. On September 8, 2010 the activity director was in-serviced regarding activities guidelines. The SNF Manager or designee will audit 5 charts per month for accurate and appropriate activity documentation and report to the quarterly QA meeting.	09/25/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Chief Executive Officer* (X4) DATE *9-8-10*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 088443	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 09/11/2010
NAME OF PROVIDER OR SUPPLIER GEORGE L. MEE MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 500 CANAL STREET KING CITY, CA 93950	
(04) 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)	(05) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 8/8/10 through 8/11/10.</p> <p>The facility was licensed for 18 beds. The census at the time of the survey was 16. The sample size was 8.</p> <p>Representing the California Department of Public Health: Kathleen Sullivan, Health Facilities Administrator; and Irina Koshlinsk, Health Facilities Administrator.</p> <p>ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing activity program that met the needs of three of eight sampled residents (8, 3, and 5), and activity staff failed to provide documentation according to policies and procedures. Findings:</p> <p>1. On 8/11/10, Resident 9's clinical record indicated his interests included exercise, sports, music, reading, trips, shopping, being outdoors, watching TV and movies in room, talking, and listening to the radio in his room. A review of Resident 9's activity progress notes dated</p>	F 000	<p>SEP 23 2010 L & C DIVISION SAN JOSE</p> <p>F248 403.15(7)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>Requirements not met as evidenced by... the facility failed to provide an ongoing activity program that met the needs of three... residents, and activity staff failed to provide documentation...</p> <p>On September 8, 2010 the three residents were interviewed by the activities director and their care plans were updated. By September 26, 2010 the admission screening and ongoing needs assessment and documentation tools will be reviewed and revised as needed, and the Activities Policy and Procedure will be updated to include the wording, "For residents with no discernable response, service provision is expected and may include one-to-one activities such as talking to the resident, reading to the resident about prior interests, tactile and olfactory stimulation, applying lotion to skin, and so on."</p> <p>A Daily Activities Record will be developed by September 26, 2010 to include the activity participated in, where the activity took place (i.e. group or in-room), the degree of participation (i.e. active, passive, etc.), and the duration of the activity.</p>	09/26/2010
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(06) DATE

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NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930
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F 248	<p>Continued From page 2</p> <p>In the activity sessions and had asked for them. A review of Resident Council minutes for 5/10, 6/10, and 7/10 indicated a request for exercise and games at all three meetings. There were only follow-up notes for the 6/10 meeting which listed exercise on 8/3 and 6/11/10. There were no follow-up notations to the requests for 5/10 or 7/10.</p> <p>The Activity Calendar for 6/10 scheduled exercise and games once on 6/11/10, and games alone on 8/3/10. The 7/10 and 8/10 Activity Calendars scheduled one exercise and games activity each month on 7/1/10 and 8/31/10.</p> <p>4. Resident 3 was unable to communicate verbally or by written word. The 5/26/10 MDS indicated the resident was severely impaired in decision making and was totally dependent for help with activities of daily living. Resident 3's activity preferences were listed as music, spiritual/religious activities and watching TV.</p> <p>During an interview with the AD on 8/9/10 at 4:50 p.m., she stated she did not have to do room-bound activities with Resident 3 because he came out of his room a lot.</p> <p>During observations of Resident 3 on 8/8/10 at 2:20 p.m., 8/9/10 at 8:05 a.m., and 8/10/10 at 11 a.m., the resident was in his room. The TV and radio were not on. In the activity room on 8/11/10 at 10:10 a.m., while music was playing and other residents were singing, Resident 3 was lying in a geri-chair (chair that holds the entire body) with his eyes closed. During an activity the AD touched the resident's shoulder once with no response by the resident, and no other interaction was observed.</p>	F 248		

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F 248	Continued From page 3 A review of Resident 3's 6/27/10 Activity Progress Note indicated he attended activities for stimulation and for in room activities he liked to listen to music or watch and listen to TV in his native language. A review of Resident 3's 4/1/09 Activity Care Plan had the objective of attending activities for stimulation and had communication goals of talking to him in his native language and asking yes or no questions. There were no actions documented in the plan related to how the stimulation would take place, other than his attendance. 5. Resident 5's annual MDS dated 1/17/10 indicated the resident had long and short term memory problems, was moderately independent with decision making, and preferred a variety of activities including exercise, crafts and cards, but no movies. The resident's activity care plan was not individualized and did not include objectives or goals related to preferred interests in exercise, craft or cards. When reviewed on 8/09/10 for June, July and August 2010 the activity schedule did not list weekly or daily exercise, crafts, or card games for residents assessed to have such preferences.	F 248	F250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE Requirements not met as evidenced by... the facility failed to ensure social services documented communication with the responsible party for one resident. On September 8, 2010 communication with the responsible party was documented in the medical record. By September 25, 2010, Social Services will identify and document who the residents' responsible parties are for medical and/or financial matters. Social Services will include documentation for any changes in responsible party and update face sheet and care plan. Social services will update the quarterly/ annual/ change of condition assessment form to include a section for responsible party information. By September 25, 2010 the nursing staff will be in-serviced regarding informed consent documentation guidelines. The psychotropic committee will review charts quarterly to ensure accuracy, signed by appropriate responsible party, and up to date. The results will be reported to the quarterly QA meeting.	09/25/2010
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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F 250	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure social services documented communication with the responsible party for one of eight sampled residents (1). Findings:</p> <p>Resident 1 was admitted with diagnoses including pulmonary disease, dementia, Parkinson's disease (a degenerative disorder of the central nervous system) and chorea (movement disorder marked by involuntary, jerky movements, especially of the arms, legs and face). Her 5/19/10 MDS (Minimum Data Set- an assessment tool) indicated she was moderately impaired in her decision making ability and was totally dependent for help with activities of daily living.</p> <p>A review of Resident 1's clinical records on 8/8/10 indicated when readmitted on 2/19/10, she had an order for haloperidol (Haldol used to treat psychotic disorders and to control movement disorders). The dosage was 1 milligram (mg) every eight hours for a total of three mg a day for chorea. The dosage was increased on 3/17/10 to 2 mg every eight hours. Haldol was discontinued on 5/19/10. Haldol was reordered on 6/3/10 at 1 mg every eight hours. Resident 1 also received Effexor (antidepressant) and Ativan (anti-anxiety medication). All three drugs have potential side effects of drowsiness and sedation.</p> <p>In-room observations were made on 8/8 at 2:20 p.m., 8/9 at 8:06 a.m., 8/10 at 2:05 and 4:45 p.m. and 8/11/10 at 8:25 a.m. On 8/9/10 at 9 a.m., Resident 1 was able to respond to some questions, but nodded off and made some confused responses. Except during activities of</p>	F 250			

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F 250	Continued From page 5 daily living, such as dressing and being fed by staff, Resident 1 was observed sleeping in bed with her mouth open, as well as during activities. A review of Resident 1's clinical record on 8/9/10 indicated an informed consent for Haldol signed on 2/19/10 by the previous responsible party with no physician signature. There was no evidence informed consents were signed by the new responsible party after Haldol was restarted on 8/3/10. During an interview with the unit supervisor (U S) on 8/9/10 at 4:55 p.m., she stated since May 2010, Resident 1 had a new responsible party who lived out of state but could be reached by telephone. A review of the social worker's notes dated 8/15/10 made no reference to contact the new responsible party. On 8/10/10 at 10:40 a.m. during an interview with the social service worker (SSW), she stated the new responsible party and Resident 1's physician had been in touch. The SSW stated the new responsible party requested the facility help to get the financial obligations handled by a county representative, but the new responsible party would continue to handle medical decisions. The SSW was unable to provide documentation of any conversations with the new responsible party.	F 250	F252 483.15(h)(1)SAFE/ CLEAN/ COMFORTABLE/ HOMELIKE ENVIRONMENT Requirements not met as evidenced by... the facility failed to provide a clean, comfortable and homelike environment for 15 residents. On August 11, 2010 the adult diapers were moved and stored in the closet. On August 8, 2010 the portable oxygen tank was removed. On August 26, 2010 the window screens and brackets were repaired or replaced. On August 9, 2010 the power strip was removed. By September 25, 2010 the wheeled brown wood furniture will be refinished. By September 25, 2010, rooms 22, 23, and 25 will have the paint repaired. By September 25, 2010, the nursing staff will be in-serviced regarding proper storage of patient care items.	09/26/2010	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252	The SNF Manager or designee will monitor hazard rounds and work order requests to ensure follow-up in timely manner. The results will be reported to the quarterly QA Meeting for one year.		

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NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930		
(X4) ID PREFIX TAG F 252	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 252	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide a clean, comfortable and homelike environment for 15 of 15 residents residing in the facility. Findings:</p> <ol style="list-style-type: none"> 1. During the initial tour 8/8/10 and during the environmental room inspections on 8/10/10, Rooms 11, 12, 21, 22, 23, 24, 25, and 26 had multiple packages of adult diapers stored on the edges of bathroom sinks, and hanging over on shelves above the sinks. In Room 11, the multiple packages wedged between the wall and the sink prevented the hot water tap to be turned on completely. 2. A portable oxygen tank was stored in the shared bathroom in Room 22. During an interview with the unit manger at 8/8/10 at 12:20 p.m., she stated it did not belong there. 3. On 8/10/10 at 10:30 a.m. the chief engineer (CE) was present during the environmental inspection tour when the following were observed: <ol style="list-style-type: none"> a. The window screen in Room 11 had a bent frame that caused a gap between the screen and the window. Brackets were missing on window screens in Rooms 26 and 24. Multiple holes were noted in window screens for Rooms 21, 22, and 12. The holes measured 2 to 5 inches in circumference which would allow entry for insects and large pests. b. A power strip with multiple outlets was screwed into the wall in Room 11 behind bed 2 and 				

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NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930	
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F 252	Continued From page 7 plugged into an existing wall outlet located between beds 1 and 2. The CE stated this was contrary to facility policy.	F 252	<p>F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>Requirements not met as evidenced by... the facility failed to provide services which met professional standards of quality for 3 residents.</p> <p>On August 12, 2010 the tuberculin skin test documentation policy was reviewed with the nurse responsible. Admission checklist revised on September 8, 2010 to include question regarding immunizations and screenings to ensure no duplication of therapy, especially on re-admissions. On August 24, 2010 nursing staff in-serviced on proper use and documentation of medications, including the need to clarify pain medication orders if no pain scale included in physician order. On September 8, 2010 the medication vital sign policy was reviewed and revised to ensure that licensed staff is responsible for all vital signs prior to medication administration.</p> <p>On August 24, 2010 the nursing staff was in-serviced regarding vital signs for medication administration, medication documentation, and pain medication orders.</p> <p>The SNF Manager or designee will audit 5 charts per quarter for medication and pain documentation accuracy. The results will be reported to the quarterly QA Meeting for one year.</p>	09/8/2010
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services which met professional standards of quality for three of eight sampled residents (7, 5, and 10). Resident 5 received an unnecessary tuberculin skin test and the test was not documented according to facility policies and procedures. Resident 7 was administered a pain medication without physician orders. Resident 10's pulse rate was not checked as ordered before a heart medication was administered. Findings:</p> <p>1. Resident 5 was admitted to the facility with diagnoses including diabetes. The minimum data set (MDS, an assessment tool) indicated the resident had long and short term memory</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>problems, and was moderately independent with decision making.</p> <p>On 8/11/10 at 10 a.m. the record was reviewed with the infection control nurse. The record indicated Resident 5 received a tuberculin skin test (TST) on 4/14/10 despite a history of tuberculosis (TB) treatment and a negative chest X-ray in 2008. TST is administered as an intradermal injection of purified protein derivative (PPD). On 4/17/10, after the unnecessary TST Resident 5 tested positive for TB.</p> <p>The facility policy for "Tuberculosis: Resident Screening" described how all residents are screened for tuberculosis on admission and annually. The results should be recorded in millimeters.</p> <p>On 4/17/10 Resident 5's TST result was recorded on the Tuberculin Skin Test and Immunization Documentation form with a plus sign instead of measurement in millimeters (mm). The nursing staff failed to accurately record the measurements of the induration (swelling on the resident's forearm) in the nursing notes and the TST documentation.</p> <p>The infection control nurse stated Resident 10 should not have received the TST, and the TB immunization documentation was not recorded accurately as required by the policy.</p> <p>2. Resident 7 was admitted to the facility with diagnoses including end stage renal disease. Review of the physician orders on 8/9/10 indicated there was an order for Tylenol 650 mg (milligrams) every six hours as needed for a temperature greater than 101.5 degrees</p>	F 281			

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F 281	<p>Continued From page 8 Fahrenheit, and for HA (headache) mild pain.</p> <p>The medication administration record was reviewed and Resident 7 received Tylenol 650 mg twice on 8/10/10 for left arm pain, and for side pain on 8/19/10. The pain level was rated as 6 out 10.</p> <p>From 7/17/10 to 7/26/10 Resident 7 received Tylenol 13 times for body aches and earaches with pain rate rated as 8 out 10.</p> <p>On 5/29/10, Resident 7 received Tylenol 650 mg for a headache rated as 8 out of 10.</p> <p>On 8/10/10 the unit supervisor stated mild pain was rated as no higher than 3 on a scale of 0-10, with zero as no pain and ten as the worst pain. Licensed staff medicated Resident 5 without obtaining a revised Tylenol order for new pain sites and increased levels of pain.</p> <p>3. During the medication pass on 8/9/10 at 8 p.m. with licensed nurse 2 (LN 2), she administered medications to Resident 10 including propranolol (used in the treatment of hypertension). LN 2 did not check Resident 10's pulse prior to administration. Propranolol is contraindicated in patients with bradycardia (less than sixty heartbeats per minute). The physician's orders called for a pulse to be taken prior to administration, and to hold the medication if the pulse rate is below sixty beats per minute.</p> <p>During an interview with LN 2 after the administration, she stated Resident 10's pulse rate was 94. LN 2 stated she got the pulse rate from the vital sheets, which had been done between 4 to 5 p.m., by the certified nurses</p>	F 281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 068443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2010
NAME OF PROVIDER OR SUPPLIER GEORGE L. MEE MEMORIAL HOSPITAL O/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 10 assistants.	F 281	F323 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/ DEVICES	09/25/2010	
F 323 SS-E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the hospital failed to keep cleaning products and medications secure and out of residents' reach. Findings: During the initial tour on 8/8/10 starting at 11:30 a.m. with the unit supervisor (US), the following items were observed.</p> <ol style="list-style-type: none"> 1. A closet, with a sign which read "This door remains closed at all times", was open and contained multiple boxes of Polident (a denture cleanser) and alcohol free mouthwash. The manufacturer's Safety Data Sheet for Polident indicated that ingestion may lead to irritation of the throat and difficulty breathing. 2. The open medical-surgical supply room, located near Room 18, had three bottles of hydrogen peroxide (a disinfectant and bleaching agent) and three bottles of fleets enema (a saline laxative). 3. The unlocked janitor closet next to the supply room had three large deodorizer bottles in plastic 	F 323	<p>Requirements not met as evidenced by... the facility failed to keep cleaning products and medications secure and out of residents' reach.</p> <p>On August 9, 2010 the Polident and alcohol free mouthwash, hydrogen peroxide, and fleets enemas were removed from the closets. On August 8, 2010 the janitor closet was locked. On August 12, 2010 the glass flower vase was replaced by a plastic vase and the ceramic picture frame was secured to the wall. On September 20, 2010 the "Compressed Gasses" policy will be reviewed and revised to reflect the hospital's current no smoking policy. On September 8, 2010, "No Smoking" signs placed in rooms 21 and 22 where oxygen is stored. On August 10, 2010 all closets surveyed and those needing locks had them installed.</p> <p>By September 25, 2010 the nursing staff will be in-serviced regarding storage of potentially hazardous materials.</p> <p>The SNF Manager or designee will monitor hazard rounds and work order requests to ensure follow-up in timely manner. The results will be reported to the quarterly QA Meeting for one year.</p>		

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NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930
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F 323	<p>Continued From page 11</p> <p>jug-like containers. On 8/9/10 at 11:35 a.m., US stated the janitors had keys to the closet, and it should be kept locked.</p> <p>A review of the 1/04 Storage of Hazardous Materials on 8/9/10 indicated storage areas are kept under lock and key until needed.</p> <p>A review of the 12/07 Medication and Disposal Storage on the same date, indicated all drug storage areas shall be lockable and accessible to authorized personnel.</p> <p>4. In Room 11-4 a heavy glass flower vase and a ceramic picture frame were not secured to the wooden shelving to the right of the head of the resident's bed.</p> <p>5. No oxygen signage was posted outside of Rooms 21 or 22 where residents were receiving oxygen therapy.</p> <p>A review of the 1/04 policy and procedure, "Compressed Gasses", indicated, "No Smoking signs shall be prominently posted in all areas where oxidizing gases are stored, in use or present."</p>	F 323	<p>F329 483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Requirements not met as evidenced by... the facility failed to have adequate monitoring of medications for 1 sampled resident.</p> <p>On August 10, 2010 the resident's Haldol was decreased to 0.5 mg.</p>	08/24/2010
F 329 SS=0	<p>483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>	F 329	<p>On August 24, 2010 the nursing staff was in-serviced regarding the monitoring of behaviors and side effects of medications</p> <p>The psychotropic committee will review charts quarterly to ensure accuracy, signed by appropriate responsible party, and up to date. The results will be reported to the quarterly QA meeting.</p>	

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F 329	<p>Continued From page 12</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have adequate monitoring of medications for one of eight sampled residents (1). During observations, Resident 1 appeared sedated. There was no documented evidence of a signed consent or discussion of the risks versus benefits with the responsible party when Haldol was reordered by the physician. There was no evidence of a pharmacist drug regimen review of Haldol and other sedative medications Resident 1 received since her readmission in 2/10/10. Staff stated she was increasingly drowsy and showing sedated affects, however, the assessments in the Medication Administration Record (MAR) indicated she had no adverse affects from her sedative medications. There was no direct monitoring for side effects of Haldol in the MAR. Findings:</p>	F 329		

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F 329	<p>Continued From page 13</p> <p>Resident 1 was admitted with diagnoses including pulmonary disease, dementia, Parkinson's disease (a degenerative disorder of the central nervous system) and chorea (movement disorder marked by involuntary, jerky movements, especially of the arms, legs and face). Her 5/19/10 MDS (Minimum Data Set- an assessment tool) indicated she was moderately impaired in her decision-making ability and was totally dependent for help with activities of daily living.</p> <p>A review of Resident 1's clinical records on 8/8/10 indicated when readmitted on 2/19/10, she had an order for haloperidol (Haldol used to treat psychotic disorders and to control movement disorders). The dosage was 1 milligram (mg) every eight hours for a total of three mg a day for chorea. The dosage was increased on 3/17/10 to 2 mg every eight hours. Haldol was discontinued on 5/19/10. Haldol was reordered on 6/3/10 at 1 mg every eight hours. Resident 1 also received Effexor (antidepressant) and Ativan (anti-anxiety medication). All three drugs have potential side effects of drowsiness and sedation.</p> <p>In-room observations were made on 8/8 at 2:20 p.m., 8/9 at 8:05 a.m., 8/10 at 2:05 and 4:45 p.m. and 8/11/10 at 8:25 a.m. On 8/9/10 at 9 a.m., Resident 1 was able to respond to some questions, but nodded off and made some confused responses. Except during activities of daily living, such as dressing and being fed by staff, Resident 1 was observed in bed sleeping with her mouth open as well as during activities.</p> <p>During an interview with the AD on 8/11/10, she stated Resident 1 had been getting more sleepy the past couple of days, but would respond if you shook her shoulder, and the resident could</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93830		
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F 329	<p>Continued From page 14</p> <p>answer appropriately at times. Her conversations with the resident were geared to yes and no responses.</p> <p>A review of Resident 1's physician progress notes for 7/2/10 indicated Resident 1 seemed less engaged and less interactive. During an interview with the unit supervisor (U S) on 8/10/10 at 2:40 p.m., she stated Resident 1 had been overly sedated the past two days and she had not seen her three days ago. After she called Resident 1's physician, he ordered a decrease in the dosage of Haldol.</p> <p>During a review of Resident 1's MAR on 8/8/10, there was no side effect monitoring seen for Haldol. There were side effect monitoring for Effexor (antidepressant) and Ativan (anti-anxiety medication). Sedation and drowsiness were identified as possible side effects for both Effexor and Ativan. Although staff interviews indicated she was increasingly drowsy and showing sedated affects, the assessments in the Medication Administration Record (MAR) indicated she had no adverse affects from her sedative medications.</p> <p>On 8/11/10, a review of Resident 1's MAR for 7/10 and 8/10 had "0" listed for side effects on all dates up to and including 8/10/10. On 8/11/10 at 8:35 a.m. during a review of Resident 1's admission care plan for Behavior, it indicated Haldol was increased on 3/17/10, discontinued on 5/19/10 and restarted on 6/3/10. Another notation indicated the dosage had been lowered to 0.5 mg every eight hours on 8/10/10.</p> <p>During an interview with the unit supervisor (U S) on 8/9/10 at 4:55 p.m., she stated since May</p>	F 329			

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F 329	Continued From page 16 2010, Resident 1 had a new responsible party who lived out of state but could be reached by telephone. There was no documented date and time of consent by the new responsible party when Haldol was restarted on 6/3/10. A review of the social worker's notes dated 8/15/10 made no reference to contact with the new responsible party. On 8/10/10 at 10:40 a.m. during an interview with the social service worker (SSW), she stated the new responsible party and Resident 1's physician had been in touch. The SSW was unable to provide documentation of any conversations with the new responsible party. During a review of the February 2010 through August 2010 facility drug regimen review records on 8/10/10, the only drug regimen review of any drugs for Resident 1 was a reference to Claritin (non-drowsy allergy medication). On 8/10/10 at 10:30 a.m. during a telephone interview with the pharmacist (MMR MD) in charge of the drug regimen review for the facility, he stated he could not recall if he had done specific drug regimen reviews for any of Resident 1's medications since her readmission to the facility. He stated the information might be in his computer, however, there was no information provided.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 483.35(i) FOOD PROCURE, STORE/ PREPARE/ SERVICE - SANITARY Requirements not met as evidenced by... the facility failed to date opened containers...failed to have access to disposable towels at the handwashing sink. On August 8, 2010 the unlabeled food was disposed of. On August 8, 2010 paper towel roll was placed near sink. On August 11, 2010 the paper towel dispenser was replaced. On September 8, 2010 the kitchen staff was in-serviced regarding labeling, dating and, storage of food. As of August 8, 2010, the maintenance and refilling of hand washing sink supplies will be inspected daily each shift by the sanitary aides. The Dietary Manager or designee will monitor food storage and sanitation supplies. The results will be reported to the quarterly QA Meeting for one year.	09/25/2010	

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F 371	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store food under sanitary conditions when they failed to date opened containers in the kitchen refrigerators and dry storage. The kitchen staff failed to have access to disposable towels at the hand washing sink. Findings:</p> <p>1. On 8/8/10 at 11:30 a.m., accompanied by the diet aide, the following were observed during the initial tour of the kitchen:</p> <p>a. The paper towel dispenser at the handwashing sink did not dispense paper towels as needed. The cook stated the dispenser was not working properly. She had to use a key to open the dispenser, which then blocked access to the sink. The diet aide stated she did not know how to access the paper toweling in the dispenser. There were no disposable paper towels available for use in the handwashing area.</p> <p>b. Two opened and undated muffin mix boxes were observed in the pantry. According to the diet aide the boxes should have been dated when opened.</p> <p>c. Three dented, eight-ounce cans of tomato paste and chipotle were stored on a shelf. The diet aide stated dented canned goods should not be used and should have been removed from the pantry.</p> <p>d. Opened and undated containers of smokey</p>	F 371		

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F 371	Continued From page 17 ham base, garlic and chicken broth were stored in refrigerator #5. e. The shelf above the stove was coated with granular debris. The shelving between the tray line and food prep area had spilled seasonings and other grimy debris. f. The food preparation table had exposed wood on the corner and surface. The table could not be properly sanitized between uses. g. The food weight scale located on a table by the stove was partially covered with soiled, wrinkled aluminum foil.	F 371			
F 428 SS=D	483.80(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the pharmacist reviewed the drug regimen for one of eight sampled residents (1). During observations, Resident 1 appeared sedated. There was no documented evidence the pharmacist performed a drug regimen review of Haldol and other	F 428	F428 483.80(C) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON Requirements not met as evidenced by... the facility failed to ensure the pharmacist reviewed the drug regimen for 1 resident. On September 8, 2010 the Pharmacy Manager will review the resident's record for the use of Haldol. On September 8, 2010 the pharmacist was in-serviced regarding the drug regimen review standard and appropriate documentation. The Pharmacy Manager or designee will audit 5 charts quarterly for completion of drug regimen reviews. The results will be reported to the quarterly QA Meeting for one year.	09/9/2010	

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F 428	<p>Continued From page 18</p> <p>sedative medications Resident 1 received since her readmission in 2/10/10. Findings:</p> <p>Resident 1 was admitted with diagnoses including pulmonary disease, dementia, Parkinson's disease (a degenerative disorder of the central nervous system) and chorea (movement disorder marked by involuntary, jerky movements, especially of the arms, legs and face). Her 5/19/10 MDS (Minimum Data Set-an assessment tool) indicated she was moderately impaired in her decision-making ability and was totally dependent for help with activities of daily living.</p> <p>A review of Resident 1's clinical records on 8/8/10 indicated when readmitted on 2/19/10, she had an order for haloperidol (Haldol used to treat psychotic disorders and to control movement disorders). The dosage was 1 milligram (mg) every eight hours for a total of three mg a day for chorea. The dosage was increased on 3/17/10 to 2 mg every eight hours. Haldol was discontinued on 5/19/10. Haldol was reordered on 6/3/10 at 1 mg every eight hours. The manufacturer's recommended maximum dosage of Haldol is Resident 1 also received Effexor (antidepressant) and Ativan (anti-anxiety medication). All three drugs have potential side effects of drowsiness and sedation.</p> <p>In-room observations were made on 8/8 at 2:20 p.m., 8/9 at 8:05 a.m., 8/10 at 2:05 and 4:45 p.m. and 8/11/10 at 8:25 a.m. On 8/9/10 at 9 a.m., Resident 1 was able to respond to some questions, but nodded off and made some confused responses. Except during activities of daily living, such as dressing and being fed by staff, Resident 1 slept in bed with her mouth open, as well as during activities.</p>	F 428		
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F 428	<p>Continued From page 19</p> <p>During an interview with the AD on 8/11/10, she stated Resident 1 had been getting more sleepy the past couple of days, but would respond if you shook her shoulder, and she could answer appropriately at times. Her conversations with the resident were geared to yes and no responses.</p> <p>A review of Resident 1's physician progress notes for 7/2/10 indicated Resident 1 seemed less engaged and less interactive.</p> <p>During an interview with the unit supervisor (U S) on 8/10/10 at 2:40 p.m., she stated Resident 1 had been overly sedated the past two days and she had not seen her three days ago. After she called Resident 1's physician, he ordered a decrease in the dosage of Haldol.</p> <p>During a review of Resident 1's MAR on 8/8/10, there was no side effect monitoring seen for Haldol. There were side effect monitorings for Effexor (antidepressant) and Ativan (anti-anxiety medication). Sedation and drowsiness were identified as possible side effects for both Effexor and Ativan. Although staff interviews indicated she was increasingly drowsy and showing sedated effects, the assessments in the Medication Administration Record (MAR) indicated she had no adverse affects from her sedative medications. On 8/11/10, a review of Resident 1's MAR for 7/10 and 8/10 had "0" listed for side effects on all dates up to and including 8/10/10.</p> <p>On 8/11/10 at 8:35 a.m. during a review of Resident 1's admission care plan for Behavior, it indicated Halo was increased on 3/17/10, discontinued on 5/19/10 and restarted on 6/3/10.</p>	F 428			

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F 428	Continued From page 20 Another notation indicated the dosage had been lowered to 0.5 mg every eight hours on 8/10/10. During a review of the February 2010 through August 2010 facility drug regimen review records on 8/10/10, the only drug regimen review of any drugs for Resident 1 was a reference to Claritin (non-drowsy allergy medication). On 8/10/10 at 10:30 a.m. during a telephone interview with the pharmacist (MMR MD) in charge of the drug regimen review for the facility, he stated he could not recall if he had done specific drug regimen reviews for any of Resident 1's medications since her readmission to the facility. He stated the information might be in his computer, however, there was no information provided.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F441 483.65 INFECTION CONTROL, PREVENT WSPREAD, LINENS Requirements not met as evidenced by... the facility failed to ensure staff demonstrated proper infection control techniques while using stethoscopes, blood pressure cuffs and while handling food. On August 24, 2010 the nursing staff was in-serviced regarding infection control practices for blood pressure cuffs and stethoscopes. By September 25, 2010 each resident will have their own blood pressure cuff. On September 8, 2010 the kitchen staff was in-serviced regarding infection control practices for handling food. The SNF Manager or designee will conduct monthly random audits of nursing staff using blood pressure cuffs and stethoscopes and the Dietary Manager will conduct monthly random audits of kitchen staff infection control practices. The results will be reported to the quarterly QA Meeting for one year.	09/25/2010

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

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STATEMENT OF DEFICIENCIES (1) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2010
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NAME OF PROVIDER OR SUPPLIER FORGE L MEE MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 92530
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(4) 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
441	<p>Continued From page 21</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff demonstrated proper infection control techniques while using stethoscopes, blood pressure cuffs and while handling food. Findings:</p> <p>1. During the medication administration observation on 8/10/10 at 9:45 a.m. licensed nurse 3 (LN 3) placed a stethoscope on a patient to check the placement of a gastrostomy tube (a tube inserted through the abdomen into the stomach to provide nutrition and medications). LN 3 then draped the stethoscope around her neck without cleaning it. She subsequently put the stethoscope in the medication cart without cleaning it.</p> <p>2. On 8/9/10 at 11:45 a.m., the cook was observed at the lunch tray line. She used a washrag to wipe down the tray line table. The rag</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2010
NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 22</p> <p>was kept soaking in a small bucket filled with liquid located near the tray line. The cook picked up the unsanitary bucket with her gloved hand and gave it to one of the kitchen staff to refill. She proceeded to plate food, and flip the covers of the steam table pans, with the hand wearing the contaminated glove. According to the dietary supervisor on 8/10/10, the cook should have washed her hands after handling the dirty bucket. The handwashing policy required the cook to wash her hands after handling anything unsanitary.</p> <p>3. During a medication pass on 8/8/10 at 5:16 p.m. with licensed nurse 1 (LN 1), she removed a stethoscope and blood pressure cuff from the bottom medication cart drawer. LN 1 proceeded to take Resident 1's blood pressure wrapping it around the resident's right arm. After taking off her gloves, LN 1 returned the stethoscope and blood pressure cuff back to the bottom drawer.</p> <p>During an interview with LN 3 on 8/10/10 at 8:45 a.m., she stated it was the facility's policy to wipe off the stethoscope and blood pressure tubing prior to use, and after use.</p>	F 441	<p>F464 483.70(G) REQUIREMENTS FOR DINING & ACTIVITY ROOMS</p> <p>Requirements not met as evidenced by... the facility failed to provide appropriate seating during meals for 1 sampled resident and 3 non-sampled residents.</p> <p>On August 18, 2010 the table heights were shortened for the individual residents involved.</p> <p>On September 3, 2010 the certified nurse assistants were educated regarding the individual residents' tables and how to determine proper table height for any resident.</p> <p>The SNF Manager or designee will monitor hazard rounds and work order requests to ensure follow-up in timely manner. The results will be reported to the quarterly QA Meeting for one year.</p>	09/25/2010	
F 464 SS=D	<p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS</p> <p>The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 464			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 088443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2010
NAME OF PROVIDER OR SUPPLIER GEORGE L MEE MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 300 CANAL STREET KING CITY, CA 93930	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	Continued From page 23 by: Based on observation and staff interview, the facility failed to provide appropriate seating during meals for one of eight sampled residents (4) and three non-sampled residents. Findings: Resident 4 was observed in the dining/activity room during the lunch meal on 8/9/10. Resident 4's Minimum Data Set (an assessment tool) indicated she was cognitively impaired, independent with eating but needed some supervision. Resident 4 was at a table sitting on a soft cushion chair. The table top came up to her collar bone. Her meal tray was placed on the table and Resident 4 searched for her milk and water beyond the dinner plate. Three other residents, who were also seated too low at the table, sat on soft cushion chairs during meals on 8/8, 8/9, and 8/10. The unit supervisor was present during the meal observation and stated the table top was too high.	F 464		