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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055249	A. BUILDING _____ B. WING _____	C 03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(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-Licensing and Certification during a RECERTIFICATION survey. Representing the California Department of Public Health by Federal ID #: 28531 RN, HFEN, 27390 RN, HFEN, and 31258 RN, HFEN Capacity: 79 Census: 72 Sample: 15 Random: 7 Entity Reported Incident (ERI) investigated during the Recertification survey: CA00433718: Substantiated with no regulatory violation.	F 000	**Merced Nursing & Rehabilitation Center submits this plan of correction as part of the requirements under State and Federal Law. The Plan of Correction is submitted in accordance with specific requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third for evaluation and appropriate treatment modalities.** F 000 Initial Comments Amended	4/6/15
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, and administrative document review, the facility failed to: 1. Conduct pre-employment screening which included checking references and verifying previous employment for five of five newly hired (within the last year) personnel reviewed; and	F 226	F 226 Development Abuse/Neglect, ETC Policies	4/6/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/6/15

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.

APR 20 2015

CA DEPT. OF PUBLIC HEALTH
LICENSING & CERTIFICATION - FRESNO

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F 226	Continued From page 1 provide abuse training as part of orientation to one of the five newly hired employees reviewed. These failures resulted in the facility being unable to assure that they were doing all that is within their control to prevent occurrences of abuse, neglect, and misappropriation of resident property. Findings: On 3/5/15 at 9:30 a.m., staff interview and review of employee files were conducted concurrently in the Director of Staff Development's (DSD) office. The employee files reviewed included: Activities Aide (AA) 2, hired 2/3/15; Licensed Vocational Nurse (LN) 3, hired 8/27/14; Certified Nursing Assistant (CNA) 4, hired 4/8/14; Housekeeper (H) 1, hired 9/16/14; and CNA 5, hired 6/6/14. The DSD stated, "We do not do background checks. We check references and verify past employment per facility policy." The DSD confirmed the Pre-Employment Reference Check List had not been completed, nor was there any documented evidence that prior employment had been verified in any of the five employee files reviewed; and they should have been. The DSD stated CNA 4's entire "New Hire Packet" had not been completed. The DSD stated the Abuse Pre-Test and the Abuse Post-Test were required training at orientation, but not had not been completed in CNA 4's employee file. The DSD stated, "The entire New Employee Orientation Checklist, First 8 Hours, was in the CNA 4's employee file and had not been completed." The DSD stated, "All of these items in CNA 4's file should have been completed and were not." Inservice meeting attendance records indicated CNA 4 did not receive training required at orientation.	F 226	The residents were questioned during resident council and during manager rounds if any resident had been subjected to or witnessed any mistreatment, neglect, and abuse of residents and misappropriation of resident property. No other residents were found to have been effected. C.N.A. 4 & 5 has now attended abuse training. The Director of Staff Development will audit the personnel files of all staff for abuse training. All staff who has not attended abuse training in the past 12 months will attend abuse training. The abuse in-service were conducted on March 256, 27, 30, 31 and April 1, 2 and 3 2015. The Nurse Consultant will audit the personnel files for next 3 months during facility visits to ensure all employees have attended abuse training. Any negative findings will be reported to the Administrator for follow up.	4/6/15

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F 226	Continued From page 2 On 3/5/15 at 5:15 p.m., an interview and concurrent review of the copies of the incomplete abuse pre and post-test from CNA 4's employee file was conducted. CNA 4 stated he had no recall of having completed the abuse training. On 3/6/15 at 8:30 a.m., during an interview, Administrator (A) 1 stated, "We do not do background checks. Checking references and past employment is part of our pre-employment screening policy. The expectation is for references to be checked and past employment to be verified before offering new hires employment." A 1 stated he was not aware that was not done. A 1 stated all employees should have abuse training as part of their orientation. The facility's P&P titled, "Abuse Prevention Program," dated 8/2006, indicated, "...2. Our facility conducts employee background checks and will not knowingly employ any individuals who has been convicted of abusing, neglecting, or mistreating individuals. 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment or our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: a. Protocols for conducting employment background checks; b. Mandated staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions, etc..."	F 226	The Director of Staff Development will audit the personnel files of staff hired in the past 3 months for to verify orientation checklist items have been completed including reference checks. Personnel files without completed orientation checklist including reference checks and mandatory staff training/orientation programs will be completed in the next 30 days. The Nurse Resource Consultant or designee will in-service the Director of Staff Development on orientation/staff training including employee file completion and reference checks. This was done on March 27, 2015. The Nurse Resource Consultant will audit the employee files for the next 60 days during facility visits and report the findings to the Administrator for follow up. The Director of Staff Development will provide the CQI committee with a summary trend analysis of any negative findings of staff not attending abuse training for the past year will be reported for the next 3 months for review and recommendations.	4/6/15
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 3 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, clinical record and administrative document review, the facility failed to promote care for residents in a manner and environment that enhances each resident's dignity and respect for three random residents (16,17,and18) when: Random Residents 16, 17 and 18's bathroom window was partially visible to public view from the outside sidewalk and street. Findings: On 3/2/15 at 4 p.m., during initial tour, Resident 16, 17 and 18's bathroom window was observed to be two feet wide by three feet long and constructed of clear glass. The window was partially covered by a white hand towel loosely tacked above the window leaving a one inch gap of uncovered window at either side of the window and a smaller gap at the bottom of the window. Immediately below the window was a toilet with a raised seat. Outside the window was a public sidewalk and a street with cars parked along the street. On 3/2/15 at 4 p.m. during an interview in the Resident's room, Resident 18 stated he used the resident bathroom daily. Resident 18 stated, "I didn't put that towel there. It doesn't look good. I don't like it. But what if it's not there? People on	F 241	F 241 Dignity and Respect of Individuality The maintenance supervisor reviewed each bathroom window and resident room to ensure that no other rooms were affected. No other residents were found to have been effected. The bathroom window for resident's 16, 17 and 18 has been replaced by an appropriate window that is frosted so that it cannot viewed from the outside. The maintenance supervisor reviewed all the resident bathrooms windows and found no there bathroom windows to be deficient. The department managers will monitor the bathroom windows for any issues for privacy including if the windows have been frosted so that no one can view the bathroom from the outside during there weekly resident rounds and report any negative issues at the morning meeting to the Administrator for follow up.	4/6/15

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F 241	Continued From page 4 the sidewalk can see us wipe our butts. Even with the towel it's not completely covered. That's embarrassing." Review of Resident 18's clinical record indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 indicating he was cognitively intact. Resident 18's functional status was assessed as able to transfer on and off the toilet with staff assistance. On 3/3/15 at 7 a.m., during an interview in the Resident's room, Resident 17 stated he uses the resident bathroom daily. Resident 17 stated, "They must not have any curtains or they would have put them up. I don't think they would leave it [the window] like that if they had something else to put up." Review of Resident 17's clinical record indicated the resident had a BIMS score of 14. Resident 17's functional status was assessed as able to transfer on and off the toilet with staff assistance. On 3/4/15 at 11 a.m., during an environmental tour, the Maintenance Supervisor (MS) stated he did not know who put the towel up in the Residents' bathroom. The MS stated the window should not have been covered with a towel. The MS stated the window should have had smoked or clouded glass obscuring the view from the street. On 3/5/15 at 2:30 p.m., during a staff interview, Certified Nurse Assistant (CNA) 3 stated she had seen the towel hanging over the resident bathroom window. CNA 3 stated a housekeeper had reported the towel to her a few days ago. CNA 3 stated she had not reported the tacked up towel and exposed window glass to her supervisor or to the maintenance department. CNA 3 stated she probably should have reported	F 241	The maintenance supervisor will provide the CQI committee with a summary trend analysis of any negative findings that effect privacy issues in regards to windows for review and recommendations for the next 3 months.	4/6/15

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F 241 F 309 SS=E	Continued From page 5 the poorly covered window to her supervisor. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, clinical record and administrative record review, the facility failed to adequately assess and document pre and post dialysis (the process of pumping blood through an artificial kidney to remove waste products and electrolytes) care for two of two Residents requiring dialysis, (Resident 13 and Random Resident 20). These failures placed Resident 13 and 20 at risk for unrecognized complications of dialysis. Findings: On 3/5/15 at 8:35 a.m., during a concurrent clinical record review and interview with Licensed Nurse (LN) 4. Admission records indicated Resident 13 was admitted with end-stage renal disease (kidney failure) which required dialysis. Resident 13's, "Dialysis Communication Record", dated 3/4/15, was reviewed. Information had not been entered in multiple fill-in areas. LN 4 stated, "There is no dialysis access (tubing to access a large blood vessel needed in the dialysis	F 241 F 309	F 309 Provide care/services for highest well being. Medical records audited residents receiving dialysis treatment for any other missing information. No other resident were found to have been effected. Resident 13 and 20 will be re-assessed for any negative outcomes from the recent dialysis treatments. Any negative findings will be communicated to the physician for follow up. See addendum page A & B. The licensed nursing staff will be in-serviced by the Director of Nursing and/or Director of Staff Development on completion of dialysis communication records including pre and post dialysis documentation, lab results, time resident left and returned, cognitive status, breathing patterns, breath sounds, dressing and condition. A test was given at the end of the in-service with a pass rate of 70% or better to demonstrate competency in the task. The in-service was conducted on March 30 and April 7, 2015. This will be completed by April 7, 2015. See addendum.	4/6/15

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F 309	Continued From page 6 procedure) site or location documented pre-dialysis. The same information is missing post-dialysis, as well as the time the resident returned and the cognitive status assessment. The facility does not have a policy specific to completing the Dialysis Communication Record but all the information should be filled in." On 3/5/15 at 8:40 a.m., during an interview in his room, Resident 13 stated, "The staff do not check my site when I come back from dialysis." On 3/5/15 at 8:45 a.m., Resident 13's, "Dialysis Communication Record", dated 3/4/15, 3/2/15, 2/27/15, 2/25/15, 2/23/15, 2/20/15, 2/16/15, 2/11/15 were reviewed and concurrent staff interview was conducted. The Director of Staff Development (DSD) stated eight of eight Dialysis Communication Records for Resident 13 reviewed were missing multiple pieces of pertinent information that should have been filled in. Information that was missing varied from one form to another. The missing information pre-dialysis included: the time the resident left for dialysis; and the access site and location. The missing information post-dialysis included: the time the resident returned from dialysis; cognitive status; access site and location; whether lab results were received; and an assessment of Resident 13's breathing patterns and breath sounds. On 3/5/15 at 9:30 a.m., Resident 13's Dialysis Communication Records were reviewed and a concurrent interview with the Director of Nurses (DON) was conducted. The DON stated, "I would expect documentation to be complete." The DON produced nursing progress notes which indicated the information that was missing from Resident	F 309	Medical records will audit on a weekly basis the dialysis communication record and report the negative findings of any missed documentation to the Director of Nurses for follow up. The Director of Nurses will in-service each nurse again if they are listed on the medical records audit within 7 days to ensure completion. Medical Records will provide the CQI committee with a summary trend analysis of any negative findings of missing documentation for review and recommendations for the next 3 months.	4/6/15

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F 309	Continued From page 7 13's Dialysis Communication Records was not documented in the nurses notes. For (Random) Resident 20: Review of Resident 20's admission record indicated the resident was admitted with end-stage renal disease which required dialysis. Resident 20's Dialysis Communication Records, dated 3/3/15, 2/28/15, 2/26/15, 2/21/15, 2/19/15, 2/17/15, 2/14/15, 2/10/15, 2/7/15, 2/5/15, and 2/3/15 were reviewed which indicated incomplete records of pre and post dialysis assessments. On 3/5/15 at 3:15 p.m., the above records were reviewed and concurrent staff interview was conducted. LN 2 stated, "The LN is supposed to assess the resident's dressing and condition. The LN should have completed the Dialysis Communication Record and included that information." LN 2 stated the Dialysis Communication Records for 3/3/15 and 2/19/15 were missing that information. LN 2 stated the records for the others days were also incomplete in some areas and it was the LN's responsibility to complete those records. The facility's policy and procedure titled, "Hemodialysis Access Care," dated 10/2010, indicated, "...The central catheter site must be kept clean and dry at all times...The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (intervention if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis."	F 309		
F 333	483.25(m)(2) RESIDENTS FREE OF	F 333		

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F 333 SS=D	Continued From page 8 SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, administrative document review and professional reference review, the facility failed to ensure residents were free of significant medication errors when one of 15 sampled and seven random residents, Resident 19, was administered a crushed extended release dose of Metformin HCL (a slow release form of medication to control blood sugar which should not be crushed). This failure had the potential to affect the duration of the medication and the ability to stabilize Resident 19's blood sugar levels. Findings: On 3/4/15 at 8:15 a.m., during morning medication pass, Licensed Nurse (LN) 1 removed pills and capsules from Resident 19's medication supply and put them into a plastic cup. LN 1 used a battery operated pill crusher and crushed Resident 19's pills and placed the powdered pills in applesauce. LN 1 took the applesauce containing the crushed pills and fed the mixture to Resident 19 using a plastic spoon. Review of Resident 19's physician's orders for March 2015 indicated, "Metformin HCL ER Tablet Extended Release 24 Hour Give 500 mg (milligrams) two times a day..."	F 333	F 333 Residents Free of Significant Med Errors The pharmacy nurse consultant observed the licensed staff during medication pass for crushing medications. No other residents were found to have been effected. Resident 19 has been assessed for any negative outcomes from the crushed medication. Any negative outcomes will be communicated to the physician for follow up. The licensed staff will be in-serviced by the Director of Nurses and/or Director of Staff Development on following medication procedures for the dispensing of medications including non crushable medications and how to identify them during medication pass. A return demonstration will be used to test for proficiency with the medication procedure. This in-service was conducted on March 30 and April 7, 2015.	4/6/15

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F 333	Continued From page 9 On 3/4/15 at 8:30 a.m., during an interview at the medication cart outside of Resident 19's room, LN 1 stated she had crushed and administered Metformin HCL ER 500 mg to Resident 19 with her morning medications. LN 1 stated Resident 19 had difficulty with swallowing and therefore she always crushed her medications and put them into applesauce. LN 1 stated the Metformin extended release capsule should not have been crushed and the medication needed to be ordered in a different form that would not be affected by crushing. On 3/5/15 at 10:55 a.m., during an interview, the facility consultant pharmacist (CP) stated crushing Metformin ER could affect the duration of the medication and the extended effect on the blood sugar level. CP stated extended release medications generally should not be crushed as the duration of the medication could be affected. Review of facility policy and procedure "Preparation and General Guidelines IIA2: Medication Administration - General Guidelines" dated April 2008 indicated, "...a. long-acting or enteric - coated dosage forms should generally not be crushed; an alternative should be sought." Lexicomp, a nationally recognized drug database at http://online.lexi.com indicated, "Metformin... Administration...Extended release: Swallow whole;do not crush, break or chew..."	F 333	The pharmacy nurse consultant has observe the licensed nurses on April 2, 2015 and will continue to observe during monthly visits for medication pass and observe for non crushable medications and how to identify non crushable medications with all nurses and report the findings to the Director of Nurses for follow starting in April and continue on-going until no issues are observed. The pharmacy consultant will provide the CQI committee with a summary trend analysis of any negative findings for the next 3 months for review and recommendations.	4/10/15
F 371 SS=E	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	F 371	F 371 Food Procure, Store/Prepare/Serve-sanitary The Dietary Supervisor observed the dietary staff for sanitizing meal carts after each meal, the cleaning of the stationary can opener after each meal and the two compartments sink cleaning procedure. No other residents were found to have been effected.	4/10/15

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F 371	Continued From page 10 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to prepare and distribute food under sanitary conditions when: 1. Meal tray delivery carts were not sanitized. 2. Dietary Aide (DA) 1 did not follow proper procedure to sanitize dishes and utensils manually. 3. The stationary can opener was not cleaned after each use. These failures placed residents at risk of cross-contamination and disease transmission by being given foods prepared, and served on unsanitary kitchen utensils and equipment. Findings: 1. On 3/3/15 at 9:05 a.m., during an observation in the kitchen, DA 1 was observed cleaning the meal tray delivery carts after breakfast. DA 1 used a cloth from a green bucket to wipe the carts. On 3/3/15 at 9:10 a.m., during an interview, DA 1 was asked what kind of solution was in the bucket	F 371	Meal delivery carts have been sanitized by the dietary aide and are on a regular cleaning schedule after each meal. The meal delivery carts are scheduled to be cleaned after each meal. Dietary Aide 1 has been in-serviced on sanitizing meal carts after each meal including the use of the green bucket with soap and water and the use of the red bucket containing sanitizer on March 27, 2015 by the dietary supervisor. See addendum page C. The dishes, pots and pans have sanitized by the dietary aide following the policy and procedure for two compartment sink, including the immersion for at least 1 minute in solution containing 200 parts per million quaternary ammonium. The dishes, pots and pans will continue to be sanitized after each use on an on going basis using the policy and procedure for the two compartment sink. The stationary can opener has been Cleaned by the dietary aide.	4/6/15

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F 371	Continued From page 11 she used to clean the carts. DA 1 stated it was soap and water. When asked how she ensured the carts were sanitized she answered, "Once a week the facility performed a power wash outside." She did not mention the use of sanitizer. On 3/4/15 at 12:30 p.m., during a group interview with the Registered Dietitian (RD) and the Dietary Supervisor (DS), they both stated the food carts should be cleaned and sanitized after each meal. The RD stated the green bucket contained soap and water, and the red bucket contained the sanitizer. The RD stated DA 1 was expected to know the difference between the cleaning solutions in the two different colored buckets. The RD stated DA 1 should have used the sanitizer from the red bucket after cleaning the cart with soap and water from the green bucket. The facility's policy and procedure dated 2012 titled "Sanitizing Equipment, Food and Utility Carts" indicated "Food and utility carts will be cleaned and SANITIZED after each meal or use." 2. On 3/3/15 at 9:20 a.m., during an observation in the kitchen, DA 2 demonstrated the manual method of washing dishes in a two compartment sink. It was observed that DA 2 removed food particles from used pots and pans, then filled the first sink with premixed soap and hot water. She soaked the pots and pans and scrubbed them for a few seconds. DA 2 then put those pots and pans in the second compartment of the two compartment sink, and rinsed them under running water. After the pots and pans were rinsed, she filled the second sink compartment with approximately two inches of quaternary ammonium (Quat). At this point all the pots and	F 371	Dietary Aide 2 has been in-serviced on the policy and procedure for two compartment sink; sanitize dishes, immersion for at least 1 minute in solution containing 200 parts per million quaternary ammonium on March 4, 2015 by the Registered Dietician. See addendum page D. Dietary Aide 1, Dietary Aide 3, Dietary Aide 4 has been in-serviced on the policy and procedure for sanitizing equipment, food and utility carts after contact with food after each use on March 27, 2015 by the Dietary Supervisor and on March 4, 2015 by the Registered Dietician. See addendum page C, D, E & F. The dietary staff will be in-serviced on the policy and procedure for sanitizing equipment, food and utility carts, ware washing using a two compartment sink, sanitize dishes, immersion for at least 1 minute in solution containing 200 part per million quaternary ammonium and sanitizing all kitchen equipment and surfaces that come in contact with food will be cleaned and sanitized after each use.	4/6/15

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F 371	Continued From page 12 pans were only partially immersed in the two inch deep solution. DA 2 then maneuvered the pots and pans to ensure all surfaces made contact with the solution for 3 to 4 seconds. DA 2 then immediately took the coated pots and pans out of the sink and placed them on the counter to air dry. On 3/3/15 at 9:25 a.m., during an interview, when asked how she ensured the pots and pans were properly sanitized for use, DA 2 stated as long as the entire surface of pots and pans made contact with the sanitizer and air dried they were considered sanitized. On 3/4/15 at 12:30 p.m., during a group interview with the RD and the DS, they both stated the pots and pans were required to be immersed in the sanitary solution for at least one minute for the Quat to be effective. The written instruction for manual dishwashing procedure was posted on the wall above the sink, and stated the same. The RD and the DS both stated they needed to, "Train DA 2 on proper sanitization techniques again, and supervise the staff more closely." The facility's policy and procedure dated 2012 titled "Warewashing (Handwashing Method)" indicated "Two compartment sink...Sanitize dishes...Immersion for at least 1 minute in solution containing 200 ppm (part per million) quaternary ammonium." 3. On 3/4/15 from 11:30 a.m. to 11:45 a.m. during tray line observation with the RD, DA 4 used the stationary can opener to open a can of chocolate pudding. She did not clean the can opener blade before or after she used it. About 10 minutes later DA 3 brought a can of tuna and used the	F 371	A return demonstration was done by the staff in-serviced on the procedure and observed by the instructor of the in-service to ensure that the staff understood the in-service and could complete the procedure. This in-service was conducted on March 4 and March 27, 2015 by the Registered Dietician and the Dietary Supervisor. See addendum page C, D, E & F. The RD will observe the dietary staff cleaning the meal delivery carts after each meal and the use of the two compartment sink for sanitizing of dishes, pots and pans during visits for the next 3 months and report the findings to the Dietary Manager for follow up. The Dietary Manager will provide the CQI committee with a summary trend analysis of any negative findings that report the same issues that were reported during the survey for the next 3 months for review and recommendations. If the negative findings continue, the CQI committee will recommend disciplinary action to the staff that is non compliant.	4/6/15

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F 371	Continued From page 13 same can opener. She did not clean the can opener blade before or after she used it. About 5 minutes later DA 1 brought a can of tomato sauce and used the same can opener. She did not clean the can opener blade before or after she used it. On 3/4/15 at 12:30 p.m., during a group interview with the RD and the DS, they both stated the can opener blade needed to be cleaned after each use to ensure the blade remained clean and sanitary. The RD stated the food residue on the can opener blade could be an origin of food contamination if not cleaned after each use. The facility's policy and procedure dated 2012 titled "Sanitizing Equipment, Food and Utility Carts" indicated "All kitchen equipment and surfaces that come in contact with food will be cleaned and sanitized after each use."	F 371		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: *Waiver- Based on observation, and staff interview the facility failed to ensure 80 square feet of living space for each resident when Room 14 and Room 17, each with capacity for four residents, were found to have less than 80 square feet per resident. Room 14 actually had only three residents at the time of the tour, however the facility requests that the waiver	F 458	F-458 Bedrooms measure at least 80 square feet per resident. The facility will continue to ensure that residents have an adequate amount of closet space and a reasonable amount of privacy, storage space and bedside stands are accessible. Director of Staff Development will in-service facility on the importance of keeping resident rooms clear of clutter and to continuously maintain a livable safe environment for the residents on March 30, 2015 and April 6, 2015. See Addendum	4/6/15

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F 458	Continued From page 14 continue to allow capacity of four residents to both rooms. This failure had the potential for residents to be afforded a lack of a private living space, closet and storage. Findings: On 3/2/15 at 4 p.m., during the observational tour of the facility, three residents were observed to occupy Room 14 and four residents were observed to occupy Room 17. According to the waiver, Room 14 measured 292 square feet in the residential living area (73 square feet per resident). Room 17 measured 289 total square feet (70 square feet per resident). Although Room 14 and Room 17 did not provide the minimum square footage, variations were in accordance with the needs of residents in these rooms. Residents had a reasonable amount of privacy, adequate closet and storage space and bedside stands were accessible. Wheelchairs and toilet facilities were readily accessible. The residents were able to move about in the rooms and there was sufficient space for nursing care to be delivered to residents. This waiver will not adversely affect the health and safety of residents; therefore we are recommending approval of a square footage room waiver. Room # Square Feet # of Residents	F 458		

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F 458	Continued From page 15 14 292 (73 sq. ft./res.) 4 (only 3 residents at the time of tour) 17 289 (70 sq. ft./res.) 4 Recommend room waiver for the three residents in room 14 and the four residents in room 17 to continue in effect. Beth Bent, HFES Health Facilities Evaluator Nurse Request room waiver to continue in effect Facility Administrator	F 458		
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to train all employees in emergency and disaster procedures. This failure was evidenced when: 1. Certified Nursing Assistant (CNA) 2 who has worked in the facility for 10 years, did not know how to shut off any of the major utilities. 2. CNA 6, who was hired 6 months ago, could not demonstrate how to shut the gas valve off.	F 518	F 518 Train all Staff-Emergency Procedures/Drills All staff has been in-serviced on the utilities shut off including the emergency shut off and the use of the wrench and location of the wrench. The staff was able to demonstrate the procedure. No other residents were found to have been effected. Certified Nurse Assistant 2 has been in-serviced on the shut off for the major utilities. Certified Nurses Assistant 6 has been in-serviced on the gas shut off valve including the use of the wrench and the location. All staff will be in-serviced by the Contract Fire and Disaster specialist in the next 30 days on the emergency preparedness including the emergency shut off of utilities and the use of the wrench and location of the wrench.	4/6/15

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F 518	Continued From page 16 This failure had the potential to put the facility's residents, staff, and the community at risk for further catastrophe in a disaster situation when facility staff was unable to perform proper safety procedures. Findings: 1. On 3/3/15 at 9:30 a.m., during a disaster and emergency preparedness interview, CNA 2 stated she had been employed at the facility for more than ten years. CNA 2 knew the location of the gas shut off but was unable to demonstrate how to shut it off. She did not know it required the use of wrench. When asked about the main water shut off she pointed at the facility's sprinkler system. She also did not know how to shut the electricity off. She stated she needed to ask her supervisor. CNA 2 stated she has participated in fire drills and disaster training in-services in the facility. On 3/6/15 at 8 a.m., during an interview, the Director of Staff Development (DSD) stated she was in charge of emergency preparedness training for both newly hired employees and existing staff. She stated she was new to this position and had not yet had a chance to perform or evaluate disaster training. CNA 2's training record was reviewed. The orientation check list signed off on 5/3/04 indicated disaster quiz was provided and she received a passing score. The facility's in-service log indicated CNA 2 attended "Fire safety and disaster training" on 2/25/15. On 3/6/15 at 8:10 a.m., during an interview, the	F 518	All have been in-serviced by the Director of Staff Development on emergency preparedness including the emergency shut off of utilities and the use of the wrench and location of the wrench on March 26, 27, 30, 31 and April 1,2 and 3 2015. A test was given to the staff for competency. The Director of Staff Development and Maintenance Supervisor will randomly ask staff monthly the location and procedure to shut off the utilities in a emergency and report the findings to the Administrator for follow up. The Director of Staff Development will provide the CQI committee with a summary trend analysis of any negative findings including staff who could not locate the emergency shut off for review and recommendations for the next 3 months.	4/6/15

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F 518	Continued From page 17 DSD stated the class room setting in-service was not effective. She stated she needed to revise the teaching for emergency shut offs "on-site" to ensure every new employee knew how to shut all utilities off. The DSD further stated she needed to do random checks to see whether everyone knew how to shut the utilities off. Facility's current "Fire and Disaster Manual' was reviewed. It indicated " Virtually every recent fire and/or disaster reported injury involving a facility resident, visitor or staff member is traceable to the failure of personnel on the scene to follow established emergency procedures. This manual explains staff procedures that should be implemented to reduce or prevent loss of life and property in this facility during a fire or disaster. All personnel should be instructed in the requirements of this manual...EMERGENCY CONTROLS AND SHUT OFF in the event of a fire, disaster or other emergency it is essential that the staff maintain control of the facility's utilities and emergency systems. Utilities : Gas, Wrench for Gas Meter, water (domestic), Main Electricity (Location of controls were hand written in the manual) Disruption of Utilities/Services...Loss of Gas to the facility...Shut off the gas meter (if necessary)...Gas Leak In the Facility...Shut off the main gas valve...Earthquake Procedures...Utilities: check utilities. Shut off only if necessary (water, gas, electric)" 2. On 3/3/15 at 2:55 p.m., during a disaster and emergency preparedness interview, CNA 6 stated she was hired about 6 months ago. CNA 6 knew the location of the gas shut off but was unable to demonstrate how to shut off. She did not know it required a wrench and was not able to state	F 518		

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F 518	Continued From page 18 where the wrench was located. CNA 6 stated she had orientation upon hire that included fire safety and disaster preparedness. She remembered having a facility tour but did not recall if anyone actually showed her how to turn the gas valve off. On 3/6/15 at 8 a.m., during an interview, the DSD stated she was in charge of emergency preparedness training for both new hires and existing staff. She stated she was new to this position and did not have a chance to perform or evaluate the disaster training yet. CNA 6's "Injury and Illness Prevention Program Safety Training Check List" dated and signed off by formal DSD was reviewed. It contained 18 topics. It indicated "18. Review of Emergency Preparedness information and shut off Locations." A single vertical line was drawn from topic 1 through 18 indicating every topic was reviewed. The facility's in service log was reviewed. CNA 6 did not sign in for the "Fire safety and disaster training" on 2/25/15. When asked how the DSD was tracking staff who missed the scheduled disaster training, she stated she needed to develop a system to ensure every staff received on going disaster training twice a year. On 3/6/15 at 8:10 a.m., during an interview, the DSD acknowledged the class room setting inservice was not effective. She stated she needed to revise the teaching for emergency shut offs "on-site" to ensure every new employee knew how to shut all utilities off. She further stated during she needed to do random checks to see whether everyone knew how to shut the utilities off.	F 518		

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F 518	Continued From page 19 Facility's current "Fire and Disaster Manual' was reviewed. It indicated " Virtually every recent fire and/or disaster reported injury involving a facility resident, visitor or staff member is traceable to the failure of personnel on the scene to follow established emergency procedures. This manual explains staff procedures that should be implemented to reduce or prevent loss of life and property in this facility during a fire or disaster. All personnel should be instructed in the requirements of this manual...EMERGENCY CONTROLS AND SHUT OFF In the event of a fire, disaster or other emergency it is essential that the staff maintain control of the facility's utilities and emergency systems. Utilities : Gas, Wrench for Gas Meter, water (domestic), Main Electricity (Location of controls were hand written in the manual) Disruption of Utilities/Services...Loss of Gas to the facility...Shut off the gas meter (if necessary)...Gas Leak In the Facility...Shut off the main gas valve...Earthquake Procedures...Utilities: check utilities. Shut off only if necessary (water, gas, electric)"	F 518		