Accepted 4/10/18 # 14042

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056417	A. BUILDING _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW HEIGHTS CONV HOSP	12819 S. AVALON BLVD LOS ANGELES, CA 90061

(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 Department of Public Health during Recertification Survey, and Facility Reported Incidents (FRIs) investigations. FRI: CA00576989 - Substantiated with no regulatory violations FRI: CA00397809 - Substantiated with no regulatory violations FRI: CA00576206 - Substantiated with no regulatory violations FRI: CA00414791 - Substantiated with no regulatory violations Representing The Department of Public Health: Surveyor ID: 38356, RN, HFEN Surveyor ID: 30840, RN, HFEN Surveyor ID: 38331, RN, HFEN Surveyor ID: 36728, RN, HFEN Total Resident Population: 159 Total Sample Size: 32 Highest Severity and Scope: E	F 000	View Heights Convalescent Hospital 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 regulatory requirements. By submitting this POC, View Heights Convalescent Hospital does not admit or concede the facts and contentions cited, or the existence or scope or severity of the deficiencies and conditions cited in the 2567. The POC is submitted to comply with federal and state law. View Heights Convalescent Hospital respects the allegations made in the 2567, have acted and will continue to act to implement this POC. 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 it employees, agents, officers, directors or shareholders.	4/09/18

RECEIVED
APR 09 2018
By _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John E. Jhsa	Administrator	4/9/18

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

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F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language	F 573	**CORRECTIVE ACTION:** Residents 69, 107, 44, 46, and 11 are no longer residents at View Heights Convalescent Hospital. Activity Director informed Resident 12 of his right to access his medical records on March 23, 2018. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** All department managers made rounds from March 26, 2018 to March 30, 2018 and interviewed residents. No similar findings were identified. Activity Director informed the residents of their right to access their medical records during the Resident Council Meeting on March 00, 2018. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Activity Director added in the Resident Council Meeting agenda a reminder to the residents of their right to access their medical records on March 20, 2018. DSD will provide training and education to all facility staff regarding resident's rights with emphasis on residents' right to access their medical records by April 12, 2018.	4/09/18 4/09/18 4/09/18

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

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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F 573	Continued From page 1 that the resident can understand. Summaries that translate information described in paragraph (g) (2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, during the group meeting six of 6 residents stated the staff had not informed them about having the right to access their medical records. This deficient practice denied the residents to exercise their rights by not knowing they could access their medical records. Findings: On March 13, 2018, at 10:15 during the group meeting six of 6 residents complained of not knowning they had the right to access their medical records. A review of the resident's group meeting for the past three months did not mention the residents were informed of their right to accessed their medical record and if they requested to view their medical records from the activity department. On March 15, 2018 at 2 p.m., an interview with the Activity Director (AD) was conducted about the residents not being informed about their right to accessed medical records. AD stated the residents were not informed about their rights to view their medical records during group meeting	F 573	Department managers will make weekly rounds and interview residents to ensure awareness of their right to access their medical records. Any deficient findings will be corrected as identified and will be reported to the Administrator. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Activity Director will monitor compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/9/18

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F 573	Continued From page 2 but arrangement could be done for the ones who requested. According to the State Operational Manual (SOM), resident has the right to review upon request oral or written to access all records including clinical records within twenty four hours excluding weekends and holidays (SOM P. 153 April 2009).	F 573		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (I) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (II) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (I) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (II) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (III) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (IV) The facility shall not make available identifying information about complainants or residents.	F 577	**CORRECTIVE ACTION:** Residents 69, 107, 44, 46, and 11 are no longer residents at View Heights Convalescent Hospital. Activity Director informed Resident 12 of his right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility on March 23, 2018. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** All residents are identified to have the potential to be affected by the deficient practice. Activity Director informed the residents of their right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility during Resident Council Meeting on March 20, 2018.	4/09/18 4/09/18

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F 577	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to inform six of 6 (Resident 69, 107, 44, 12, 46, and 11) residents, of the right to examine the results of the most recent Survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The Survey results was posted inside a locked lobby, where the residents were not able to have access. The deficit practice had the potential to misinform the residents about the quality of care the facility provided. Findings: On 03/13/2018 at 10:19 a.m., during the resident council meeting the residents were asked if previous survey results were reviewed with them and if they had the opportunity to voice their concerns. The six of the 6 members in attendance, verbalized they were not made aware of previous survey results. The survey results are posted in the facility lobby and the residents are locked out of the lobby because it is a secured locked facility. During an interview with the activity director (AD) on 03/15/2018 at 2:10 p.m., acknowledged the survey results were not readily accessible to the residents. The AD stated if the residents requested to see the survey results they would	F 577	All nursing stations (North, South Front, South Back) and Social Services offices were provided with binders containing results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility on March, 20 2018. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Signs detailing the locations where to access the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility were posted by the hallways across nursing stations and social services offices on March 20, 2018. Activity Director added in the Resident Council Meeting agenda a reminder to the residents of their right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility and the locations and availability of the survey results in the facility on March 20, 2018. DSD will provide training and education to all facility staff regarding resident's rights with emphasis on residents' right to examine the results of the most	4/09/18

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F 577	Continued From page 4 honor their request. The AD was unable to provide documentation of a residents request to review survey results, or if survey results were reviewed with residents in previous meetings. According to the Health Care Financing Administration (hhs.gov) indicated each certified nursing home is required to post a notice giving the location and availability of the survey results. The nursing home must also make the results available for examination in a place readily accessible to residents and frequented by most residents, such as in the facility lobby or dining area.	F 577	recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility and the locations and availability of the survey results in the facility by April 09, 2018. Department managers will make weekly rounds and interview residents to ensure awareness of their right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility and the locations and availability of the survey results in the facility. Any deficient findings will be corrected as identified and will be reported to the Administrator.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578	**MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Activity Director will monitor compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	04/09/18

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F 578	Continued From page 6 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the residents and or residents' responsible party information on Advanced Directives (an individual's wishes regarding medical treatment) for 17 of 32 sampled residents (Resident 1, 4, 29, 45, 51, 81, 92, 94, 95, 109, 132, 140, 142, 145, 147, and 357). The deficient practice had the potential for violating the residents wishes about their medical care when the individual was incapacitated. Findings: a. On March 14, 2018 at 1:00 p.m., the Director of Nursing (DON) was asked to provide advance	F 578	**CORRECTIVE ACTION:** Social Services department contacted each conservator for Residents 1, 4, 29, 45, 51, 81, 92, 94, 95, 109, 132, 140, 142, 145, 147, and 357 and was asked about an Advance Directive prior to admission. All 17 responses were "no" – they did not have an Advance Directive. This was documented in the clinical record. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** All residents are identified to have the potential to be affected by the deficient practice. Social Services department asked residents/responsible agents if they had an Advance Directive (prior to admission) and were provided information on Advance Directives, a copy of "Your Right to Make Decisions About Medical Treatment" pamphlet (information on making medical decisions and advance directive information) along with discussion about this right was offered to resident and responsible agent who wished to discuss this issue. Their response and information provided is documented in their clinical record.	4/09/18 4/09/18

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F 578	Continued From page 6 directives for 8 of the sampled residents. The DON provided the admissions agreement for Residents 1, 4, 29, 45, 51, 95, 140, and 145, which indicated the facility will treat the resident, and if in an emergency, they will follow the direction of a person with legal authority to make medical decisions. The DON stated the residents, responsible party, or conservator was responsible for providing the facility with the residents advance directives during the admission process or shortly there after. The DON was asked if the facility followed up with the residents, responsible parties, or conservator for the advance directive and to provide documentation. However, there was no documentation of the facility following up with the residents, responsible party, or conservator for an advance directive was provided. During an interview with the Social Service Designee (SSD) on March 15, 2018 at 1:15 p.m., stated Social Service Directors was responsible for obtaining Advance Directives from the residents, responsible parties, or conservator. The SSD stated any resident without an advance directive will be treated as a full code. The facility's policy and procedures titled "Advance Directives", dated January 2017 indicated prior to or upon admission, the facility will ask residents private conservator, or their Public Guardian about the existence of any advance directives. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, the facility will require a copy of such directives be included in the medical record. Residents who are	F 578	**MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Social Services Directors will monitor compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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F 578	Continued From page 7 conserved by the Los Angeles County Department of Public Guardian's office who do not have an advance directive in place will be deemed as full code, unless instructed by the Public Guardian's Office. b. During an interview on 3/13/18 at 12:06 PM, Social Services Director (SSD) stated Residents 81, 92, 94, 108, 132, 142, 146, 147, and 357, responsible parties were informed about Advanced Directives but thee was no follow ups made to ensure if they wanted to formulate one. SSD was not able to provide documentation to support attempts to remind the resident's responsible party to complete an Advanced Directives. During an interview on 03/13/18 12:19 PM the Director of Nursing (DON) stated "I have looked in residents medical records but can't find follow up or attempts to offer advanced directives." During an interview on 3/14/18 at 8:41 AM, the DON and SSD stated Resident 81's responsible party was offered Advanced Directives information, but the facility did not follow up to ensure if they wanted to formulate one. During an interview on 3/14/18 at 8:52 AM, SSD stated Advanced Directives information was not offered to Resident 58 or the resident's responsible party. The facility's policy and procedures titled	F 578		

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F 578	Continued From page 8 "Advanced Directives" dated 1/2017, indicated prior to, or upon admission, the facility asks residents private conservator, or their public guardian, about existence of any Advanced Directives. The policy indicated should a resident indicate that he or she has Advanced Directives the facility would request for a copy to be included in the medical records.	F 578		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(8). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	**CORRECTIVE ACTION:** MDS nurse reviewed and updated Resident 77's psychotropic medication care plans to reflect each category of medications in use including potential adverse effects on April 4, 2018. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** MRD conducted an audit on residents' psychotropic medication care plans from March 28, 2018 to March 30, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** The DON will provide training and education to all licensed nurses regarding care-planning p/p with emphasis on developing medication care plans to reflect each category of medications in use including potential adverse effects by April 12, 2018.	4/09/18 4/09/18 4/09/18

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F 656	Continued From page 9 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, the facility failed to developed a comprehensive care plan for the use of psychotropic medications (medications used to treat mental disorders), such as Ativan (used to treat anxiety), Ambien (used as to induce sleep), Benztropine (used to control tremors and stiffness of the muscles due to certain antipsychotic medicines), and Clozaril (used to treat thought disorder with potential serious side effects), to be monitored for possible adverse effects for one of 32 sampled resident (Resident 77). This deficient practice had the potential of exacerbating the Resident 77's condition and not identifying possible side effects of the medications. Findings: On March 9, 2018 at 9:30 a.m., during the initial	F 656	The MRD will conduct a care plan audit weekly to monitor facility's compliance. Any deficient findings will be corrected as identified by licensed nurse and will be reported to the DON. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** MRD will monitor compliance weekly and findings will be reported to DON. DON and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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	056417	A. BUILDING _____ B. WING _____	03/15/2018

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F 656	Continued From page 10 review of Resident 77's clinical records it revealed the resident had a comprehensive care plan for psychotropic medications. However, the care plan was not specific for Ativan, Benztropine, Clozaril, and Ambien use. According to the admission records Resident 77 was admitted to the facility on December 22, 2017 with diagnoses that included paranoid schizophrenia (alter thought disorders) and hereditary spherocytosis (abnormal shape of red blood cells). The admission Minimum Data Set (MDS), a standardized assessment and care screening tool, dated January 4, 2018 indicated Resident 77 had cognitive ability to make self understood and understand others. The resident required extensive assistance from the staff for activities of daily living. The care area assessment (CAA) was triggered for psychotropic medications indicating the staff must do frequent assessment for psychotropic adverse side effects. A review of Resident 77' undated comprehensive care plan indicated a concern for psychotropic medications related to schizophrenia. The goal was the resident would remain free of psychotropic complications by interventions such as monitoring for adverse side effects. However, the care plan intervention section did not specifically include what the adverse side effects listed was for each psychotropic medication (Ativan, Clozaril, Benztropine and Ambien).	F 656		

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F 656	Continued From page 11 A review of the physician orders dated December 22, 2017 indicated the following by mouth: 1. Ativan tablet 2 milligram (mg) give 1 tablet every 8 hours mild for agitation/anxiety. 2. Benztropine Mesylate tablet give 1 mg two times a day for paranoid schizophrenia, 3. Clozaril Tablet 25 mg a.m. for schizophrenia 4. Ambien 10 mg one tablet as needed bedtime. A review of Resident 77's medication administration records (MARs) for the months of December, 2017, February 2018 and March 2018 indicated the resident had received Ativan, Benztropine, Clozaril, and Ambien psychotropic medications. On March 9, 2018 at 1030 a.m., during an interview with Registered Nurse (RN 20) was asked why Resident 77's comprehensive care plan was not specifically related to the actual psychotropic medication used instead of combining all the medications on the same care plan that were not from the same category. RN 20 agreed the care plan should be individualize if the psychotropic was not from the same category.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		

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F 668	Continued From page 12 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, the facility failed to meet professional standard by not maintaining uniformity when charting for monitoring account of the attempts for suicidal behavior as ordered by the physician for one of 32 sampled resident (Resident 77). This deficient practice had the potential for an inadequate assessment of the resident's mental status. Findings: On March 9, 2018 at 9:30 a.m., during the initial review of Resident 77's clinical records it revealed the resident had a monitor record for monitoring behavior for suicidal ideation by tallying with hash marks per shift if the behavior occurred such as verbalization of self harm or self destructive thoughts and actions. However, the abbreviations used by the staff to interpreted the resident's behavior of acting out was without uniformity or clarity. According to the admission records Resident 77 was admitted to the facility on December 22, 2017 with diagnoses that included paranoid schizophrenia (alter thought disorders) and hereditary spherocytosis (abnormal shape of red blood cells). The admission Minimum Data Set (MDS), a	F 668	**CORRECTIVE ACTION:** The EHR software generated feature that allows licensed nurses to enter Not Applicable on the resident's behavior monitoring record, which appears on the EMAR as an "x", was immediately disabled as of March 20, 2018. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** MRD conducted an audit on residents' EMAR focusing on behavior monitoring records from March 28, 2018 to March 30, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** The EHR software generated feature that allows licensed nurses to enter Not Applicable on the resident's behavior monitoring record, which appears on the EMAR as an "x", was immediately disabled as of March 20, 2018. The DON and DSD provided training and education to all licensed nurses regarding charting and documentation p/p with emphasis on selecting appropriate chart codes on the behavior monitoring records from March 20, 2018 to April 4, 2018.	4/09/18 4/09/18 4/09/18

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F 658	Continued From page 13 standardized assessment and care screening tool, dated January 4, 2018 indicated Resident 77 had cognitive ability to make self understood and understand others. The resident required extensive assistance from the staff for activities of daily living. The care area assessment (CAA) was triggered for psychotropic medications indicated the staff must do frequent assessment for psychotropic adverse side effects. A review of the physician order dated December 22, 2017 indicated to monitor Resident 77 for suicidal ideation every shift manifest by verbalization of self harm or self destructive thoughts and actions, tally with hash marks and document total of the frequency. A review of the monitoring records in regard to Resident 77's behavior for the month of February 2018 indicated abbreviations of zeros and x's listed as the dated and shift about the resident's behavior needed to be clarified. On March 9, 2018 at 9:20 a.m., during an interview with RN 20 about the different abbreviating codes being used by the staff to account for Resident 77's behavior of not manifesting suicidal behavior. RN 20 stated he did not know what the code x's indicated for monitoring the behavior nurses used. On March 9, 2018 at 3:30 p.m., during an interview with LVN 11 was asked what did the abbreviated code x indicated on the behavior record sheet for monitoring Resident 77's	F 658	The MRD will conduct an EMAR and behavior-monitoring records audit five times a week to monitor facility's compliance. Any deficient findings will be corrected as identified by licensed nurse and will be reported to the DON. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** MRD will monitor compliance five times a week and findings will be reported to DON. DON and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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F 658	Continued From page 14 behavior for suicide. LVN 11 stated the codes were not consistent but x also indicated no behavior associated with suicide. On March 12, 2018 at 9:10 a.m., during an interview with LVN 10 was asked to interpreted the abbreviations of zeros and x in regard to the Resident 77's behavior of suicide. LVN 10 stated the zeros meant there was no behavior of manifesting suicide. LVN 10 stated she was not sure what the x's indicated on the behavior record because that was not identified as a standard code on the monitor record for manifestation of behavior. LVN 10 stated the x's can be used were applicable for medications but not for monitoring resident's behavior. According to the facility's monitoring record charted codes for the month of February 2018 indicated that x was not a charting code for interpreting resident's behavior of suicide.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 684		

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F 684	Continued From page 15 failed to provided quality of care by not informing the physician about the resident refusing accu-checks (to check glucose in blood) and Lantus (medication use to treat sugar level in the blood) insulin coverage for one of 32 sampled residents (Resident 82). These deficient practice deprived the resident from receiving quality of care when refusing accu-checks and insulin coverage by not notifying the physician to determine other alternative measures to address the refusals. Findings: On February 14, 2018 at 6:25 a.m., during record review revealed Resident 82 did not receive Lantus insulin for four days without notifying the physician of the refusal. The records indicated blood accu-check was not done to determine the resident's glucose (sugar level in blood) levels. According to the admission records Resident 82 was admitted to the facility originally on September 1, 2016 and readmitted on December 26, 2017 with diagnoses that included diabetes mellitus (abnormal blood sugar). The admission Minimum Data Set (MDS), a standardized assessment and care screening tool, dated January 8, 2018 indicated Resident 82 had cognitive ability to make self understood and understand others. The resident required extensive assistance from the staff for activities of daily living.	F 684	**CORRECTIVE ACTION:** Upon verbal notification of the alleged deficient practice on March 14, 2018, RN Supervisor assessed Resident 82 and no adverse reactions and complications noted due to the deficient practice. Licensed nurse informed Resident 82's attending physician on resident's episodes of refusal of bedtime accu-check and Lantus as ordered. Resident 82's medication, hemoglobin A1C, and blood sugar ranges were reviewed with the attending physician and new order was received to discontinue the Lantus. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** MRD conducted an audit on residents' EMAR focusing on any physician order refusals from March 28, 2018 to March 30, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** The DON and DSD provided training and education to all licensed nurses regarding Medication Administration p/p with emphasis on attending physician notification for any physician order refusals in accordance to the facility policy from March 14, 2018 to March 20, 2018.	4/09/18 4/09/18 4/09/18

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F 684	Continued From page 16 A review of the physician order dated December 26, 2017, indicated Lantus solution 100 unit/milliter (ML), inject 10 units subcutaneous (under the skin) at bedtime (9 p.m.) related to type 2 diabetes mellitus. The order indicated to hold the insulin if blood sugar was less than 80 mg/dl, give 4 ounce (oz) of orange juice and to call physician for blood sugar above 500 milligram (mg)/dl. A review of the medication administration record (MAR) indicated blood sugar levels and Lantus insulin were not given for March 2018: 1. March 1- 4 2. March 6 - 7 3. March 11 - 12 On March 14, 2018 at 8:25 a.m., during an interview with Licensed Vocational Nurse (LVN 12) was asked why the Lantus insulin was not given based on MAR. LVN 12 stated the dates on the MAR when there was an x, it indicated blood sugar level was not checked and insulin was not given. When LVN 12 was asked did the nursing staff notify the physician of days the insulin was not given, LVN 12 stated she was not sure but would provide the nurse notes on Resident 82. A review of the nurse's progress notes dated for the month of March 1 - 4, 2018 indicated nursing	F 684	The MRD will conduct an EMAR audit five times a week to monitor facility's compliance. Any deficient findings will be corrected as identified by licensed nurse and will be reported to the DON. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** MRD will monitor compliance five times a week and findings will be reported to DON. DON and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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F 684	Continued From page 17 staff did not notify the physician about Resident 82 refusing blood sugar level checks for four days. The notes also indicated Lantus insulin was not administered to the resident. On March 14, 2018 at 3:23 p.m., during an interview with Director of Nursing (DON) was asked what the nursing staff required to do when Residents 82 refused Lantus insulin for consecutive day with periods of two days within the March 2018. The DON stated the nursing staff should have informed the physician about the resident refusing Lantus insulin. According to the facility's policy and procedures dated 2017 titled "Blood Sugar Monitoring," indicated that the facility is responsible for providing care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect for full recognition of his or her individuality.	F 684		
F 742 SS=D	Treatment/Srvcs Mental/Psychosocial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced	F 742		

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F 742	Continued From page 18 by: Based on observation, interview and record review, the facility failed to follow physician order by not administering Benadryl with the psychotropic medication (capable of affecting the mind, emotions, and behavior) to decrease potential side effects of Prolixin for one of 32 sampled residents (Resident 38). The deficient practice had the potential to not achieve the therapeutic effects, causing discomforting side effects such as tremors (an involuntary quivering movement), which could be embarrasing to the resident. Findings: On 3/14/2018 at 3:00 p.m., during record review of Resident 38's medication administration records (MAR) from February 1, 2018, through March 14, 2018, indicated the physician ordered Prolixin tablet 5 milligrams by mouth every 8 hours as needed for moderate agitation, which was to be administered with Benadryl 50 milligram tablet by mouth. Resident 38 received Prolixin tablet on February 1, 2, 6, 7, 8, 18, 19, and on March 4, and 10 2018. A review of Resident 38's care plan "uses of psychotrophic medications" dated 12/19/2017, indicated the intervention was to administer psychotrophic medications as ordered by physician, monitor for side effects and effectiveness every shift, monitor/document/report as need any adverse reactions of psychotrophic medications such as	F 742	**CORRECTIVE ACTION:** Upon verbal notification of the alleged deficient practice on March 14, 2018, RN Supervisor assessed Resident 38 and no adverse reactions and complications noted due to the deficient practice. Licensed nurse informed Resident 38's attending physician on the missed medication administration of Benadryl with psychotropic medication as ordered. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** MRD conducted an audit on residents' EMAR focusing on the consistency of physician orders and medication administration and documentation from March 28, 2018 to March 30, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** The DON and DSD provided training and education to all licensed nurses regarding Medication Administration p/p with emphasis on ensuring consistency of physician orders and medication administration and documentation from March 14, 2018 to March 20, 2018. The MRD will conduct an EMAR audit five times a week to monitor facility's compliance. Any deficient findings will be corrected as identified by licensed nurse and will be reported to the DON.	4/09/18 4/0918 4/0918

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F 742	Continued From page 19 unsteady gait, tardive dyskinesia (a disorder that results in involuntary, repetitive body movements such as grimacing, sticking out the tongue or smacking of the lips), frequent falls, and loss of appetite. A review of the MAR for Benadryl indicated Resident 38 never received Benadryl for the month of February 2018. The MAR for March 2018, indicated Resident 38 received Benadryl once, on March 11, 2018 at 09:01 a.m. However, the Benadryl was not administered with Prolixin as the physician ordered. Resident 38 received the medication Prolixin 9 times but it was not administered with Benadryl as ordered by the physician. Resident 38 received Benadryl once and it was not administered with Prolixin as the physician ordered. A review of Resident 38's admission records indicated Resident 38 was readmitted to the facility on 08/01/2017, with diagnoses of schizoaffective disorder, and bipolar type (a mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). A review of Resident 38's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated December 15, 2017, indicated Resident 38 had clear speech, the ability to express ideas and had clear comprehension (understanding). The MDS further indicated Resident 38 was assessed as independent with walking, dressing, and toileting	F 742	**MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** MRD will monitor compliance five times a week and findings will be reported to DON. DON and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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F 742	Continued From page 20 use. During the interview with the Director of Nursing (DON) on 3/14/2018 at 3:11 p.m., reviewed Resident 38's MAR and stated if Benadryl was not given as ordered by the physician "the resident may not achieve a therapuetic effect". The facility's policy and procedures titled "Gradual Dose Reduction", dated January 2017, indicated each resident's psychotropic drug regimen is free from unnecessary drugs, including drugs prescribed in excessive dosages, for excessive durations, without adequate monitoring and indications for use, or in the presence of adverse consequences.	F 742		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757	**CORRECTIVE ACTION:** Resident #157 no longer resides at View Heights Convalescent Hospital. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** MRD conducted an audit on residents on GERD medications, DON and designee reviewed residents' medication orders focusing on excessive duration from March 26, 2018 to March 30, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** The DON and DSD provided training and education to all licensed nurses	4/09/18 4/09/18 4/09/18

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F 757	Continued From page 21 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure Famotidine (blocks the release of stomach acid) medication for one of 3 closed sampled residents (Resident 157) was adequately monitored and assessed for excessive duration of its use. This deficient practice had the potential for over medication and underlying causes of heartburn to go undiagnosed. Findings: On February 14, 2018 at 8:25 a.m., during a close record review revealed Resident 157 had been receiving Famotidine (blocks the release of stomach acid). According to Resident 157's admission records indicated the resident was admitted to the facility on August 8, 2016 for diagnoses that included schizophrenia (a combination of hallucinations, delusions, disordered thinking and behavior that impairs daily living), Diabetes Mellitus (high blood sugar), heartburn and substance abuse. The admission Minimum Data Set (MDS), a standardized assessment and care screening	F 757	regarding Unnecessary Drugs p/p with emphasis on excessive duration from April 4, 2018 to April 6, 2018. Pharmacy consultant will continue to conduct residents' medication regimen review monthly and recommend accordingly preventing the use of unnecessary drugs. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Pharmacy consultant will monitor compliance monthly and findings will be reported to DON. DON and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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F 757	Continued From page 22 tool, dated August 23, 2017 indicated Resident 157 had cognitive ability to make self understood and understand others. The resident required extensive assistance from the staff for activities of daily living. A review of physician order for Resident 157 indicated an order dated August 9, 2016 for 20 milligrams (mg) of Famotidine to be administered twice daily by mouth. A review of the medication administration records for Resident 157 dated August 9, 2016 through December 9, 2017 indicated Famotidine 20 mg was administered twice daily as ordered. On March 15, 2018 at 11:22 a.m. during a concurrent interview and record review with the Director of Nursing (DON) stated there was no Drug Review Review by the pharmacy consultant to address the over use of Famotidine. The DON also indicated there was no recommendations from pharmacy to reduce the dose or further assess Resident 157 to find the cause of the heartburn. According to the website www.Drugs.com, the manufacture of Famotidine recommends the medication should be used for short-term treatment of heart burn.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		

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F 761	Continued From page 23 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed: 1. To separate oral ([PO] by mouth) from rectal ([PR] through rectum) medications in back South Medication room. 2. To discard expired medications and wound dressings. The deficient practices had the potential to administer medications through a wrong route which could harm the residents.	F 761	**CORRECTIVE ACTION:** Upon verbal notification of the alleged deficient practice on March 9, 2018, the licensed nurse immediately separated the box of suppositories (rectal medication) from the oral medications. The licensed nurse immediately discarded the expired xeroform gauze, Epson saltbox, and suction catheter. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** RN supervisor and licensed nurses conducted a random spot check in all medication rooms and medication carts from March 9, 2018 to Mach 13, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** DON and DSD provided training and education to all licensed nurses regarding Storage of Medications p/p with emphasis on separating internal medications from external medications, checking expiration dates of items in use and discarding expired items from March 23, 2108 to April 5, 2018. Central Supply conduct an audit monthly of formulary items for expiration dates and assessing the condition of each item prior to distribution for use on the floor. Any deficient findings will be corrected as	4/09/18 4/09/18 4/09/18

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F 761	Continued From page 24 Findings: a. During South back Medication room inspection on 3/09/18, at 2:49 PM, Licensed Vocational Nurse (LVN 2) and LVN 4 witnessed the following; 1. There was 14 Dulcolax suppositories (rectal medication to aid bowel movement) stored next to several oral medications. 2. There was 14 Xeroform Petrolatum Dressing (for wound care) that had already expired on 10/2017. During a concurrent interview, LVN's 2 and LVN 4 stated the oral and rectal medications were to be stored on separate selves because of potential of administering them through the wrong route. LVN 4 stated charge nurses were responsible to check medication room every month for expired products and medications. b. During North Station medication inspection room on 3/09/18 at 3:01 PM, accompanied by LVN 3 the following was observed: 1. The Epson Salt that was opened in 11/17/11, but was still in circulation 2. There was one suction catheter which was expired on 5/2017. During a concurrent interview, LVN 3 stated expired medications and medical products were potentially contaminated and not safe used on the residents. LVN 3 stated licensed nurses were	F 761	identified and will be reported to the DON. RN supervisors will conduct a random spot check in all medication rooms and medication carts every shift. Any deficient findings will be corrected as identified by licensed nurse and will be reported to the DON. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** DON and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18

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F 761	Continued From page 25 supposed to check the medication room daily. The facility's policy and procedures titled "Storage of Medications" dated 1/2017, indicated internal medicines are stored separately from external medications with the exception of regularly used eye drops and topical creams, which may be stored with internal medications.	F 761		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a well balanced diet that included the right portion of foods as listed on the daily scheduled lunch menu for six of 6 sampled residents. This deficient practice had the potential to cause weight loss for all the residents. Findings: On March 13, 2018 at 10:15 during the group meeting six of 6 residents complained of food portion size being too small. The residents stated the medications they were taking made them hungry.	F 800	**CORRECTIVE ACTION:** Upon verbal notification of the alleged deficient practice on March 16, 2018, Dietary Supervisor provided retraining and education to the responsible Dietary Staff on serving correct portions of foods and ensuring consistency of food listed on the menu and the actual food being served in order to provide residents with a nourishing, well balanced diet that meets their daily nutritional needs. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** All resident are identified to have the potential to be affected by the deficient practice. The Dietary Supervisor reviewed the Resident's menu to ensure that each diet contains the right amount of foods, and portion sizes for serving taking into consideration residents' nutritional requirements on March 16, 2018.	4/09/18 4/09/18

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F 800	Continued From page 26 A review of the dietary menu dated for March 14, 2018 indicated the following foods were to be served for the residents for lunch: 1. Vegetable Soup 2. Chicken Nugget /Patty with Gravy 3. Garden Salad with Salad Dressing 4. Bread/Margarine 5. Ice cream 6. Milk On March 14, 2018 at 11:45 until 1 p.m., during a meal observation revealed the residents did not received the portion of foods listed on the lunch menu. The residents only received four pieces of chicken nuggets, small portion of french fries, and salad dressing. However, when compared to the daily scheduled menu for March 14, 2018, the residents lunch was inadequate. On March 15, 2018 at 2:40 p.m., during an interview with the Dietary Supervisor (DS) about the small portion of foods provided for lunch when the residents only received small portions of chicken nuggets, salad dressing and french fries. The DS stated it was an error for not giving the residents the right portions of food as listed on the menu. The DS agreed the residents needed all their food because the medications (psychotropic medications) the residents are	F 800	**MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Dietary Supervisor provided training and education to the all Dietary Staff regarding General Food Preparation and Handling p/p with emphasis on serving correct portions of foods and ensuring consistency of food listed on the menu and the actual food being served in order to provide residents with a nourishing, well balanced diet that meets their daily nutritional needs on March 16, 2018. Dietary Supervisor or designee will conduct a daily check on residents' menus and diet cards and trays to ensure correct portion sizes are served and residents' nutritional needs are met. Any deficient findings will be corrected as identified by dietary staff and will be reported to the Administrator. Registered Dietitian will review residents' menus monthly to ensure correct portion sizes are served and residents' nutritional needs are met. Any deficient findings will be corrected as identified by dietary staff and will be reported to the Administrator. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Dietary Supervisor and/or designee will report findings, and provide a summary trend analysis to QAPI	4/09/18 4/09/18

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F 800	Continued From page 27 taken can increase the residents appetite. The DS stated four chicken nuggets was based on policy of 2 ounce (oz) of meat. However, DS agreed it was not enough. According to the facility's policy and procedures titled "General Food Preparation and Handling," dated 2013 indicated food items will be prepared to conserve maximum nutritive value.	F 800	committee quarterly for further evaluation and/or recommendations.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure seasonings used to cook the residents foods was dated when opened, so it could be discarded before the	F 812	**CORRECTIVE ACTION:** Upon verbal notification of the alleged deficient practice on March 8, 2018, Dietary Supervisor immediately removed and discarded the Paprika and Cinnamon seasonings with no open date. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** All resident are identified to have the potential to be affected by the deficient practice. The Dietary Supervisor and designee conducted a full inspection of the kitchen and audit all food inventory, to ensure that none is expired, and those opened are dated accordingly on March 16, 2018. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** Dietary Supervisor provided training and education to the all Dietary Staff regarding Food shelf life p/p with emphasis proper procedures on food labeling and dating including seasonings; in order to correctly	4/09/18 4/09/18 4/09/18

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F 812	Continued From page 28 expiration date. The deficient practice had the potential for transmission and spreading of food borne illnesses when expired. Findings: During the initial kitchen observation and interview on 3/08/18 at 2:10 PM, the Dietary Supervisor (DS) confirmed the following seasoning was opened but not dated: 1. Five pounds of Paprika (seasoning) and 2. Cinnamon During a concurrent interview, DS stated to prevent food borne infections, it was important to ensure seasonings that had been opened, was dated to avoid contamination of the residents foods. The facility's policy and procedures titled "Food Shelf Life" dated 3/4/2016, indicated seasonings such as paprika and chili were good for 12 months from open date.	F 812	discard before the expiration date on March 16, 2108. Dietary Supervisor or designee will conduct a weekly audit of all food supplies/inventory to ensure that none is expired, and those opened are properly dated. Any deficient findings will be corrected as identified by dietary staff and will be reported to the Administrator. Registered Dietician will conduct a monthly spot check of all food supplies/inventory to ensure that none is expired, and those opened are properly dated. Any deficient findings will be corrected as identified by dietary staff and will be reported to the Administrator. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** Dietary Supervisor and/or designee will report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/18
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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F 880	Continued From page 29 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	**CORRECTIVE ACTION:** Upon verbal notification of the alleged deficient practice on March 8, 2018, Laundry Aide immediately removed the personal cell phone from the resident's clean linen and the contaminated linen was removed from the clean linen cart to be rewashed. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** ESD performed a full inspection inside the laundry on March 8, 2018. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURRENCE:** ESD and DSD provided training and education to laundry and housekeeping staff regarding Clean linen handling and Storage p/p and Cell phone policy with emphasis on infection control from March 23, 2018 to March 30, 2018. ESD will check and monitor the laundry area daily to ensure compliance in proper handling of clean linen. Any deficient findings will be corrected as identified and will be reported to Administrator.	4/09/18 4/09/18 04/09/18

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F 880	Continued From page 30 (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a personal cell phone was not placed on the residents' clean linen. The deficient practice could potentially result in contamination of residents' clean linen. Findings: During observation on 3/08/18 at 2:21 PM, Laundry Aide (LA) personal cellular phone was placed on top of the residents' clean linen. During an interview LA stated "I am not supposed to place my phone on top of the residents' clean	F 880	DSD will conduct a weekly inspection of the laundry area to ensure compliance in infection control. Any deficient findings will be corrected as identified and will be reported to Administrator. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAPI SYSTEM:** ESD and DSD will monitor compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendations.	4/09/19

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F 880	Continued From page 31 linen." During an interview on 3/08/18 at 3:56 PM, Environmental Services Director stated cell phones are never placed on clean linen because of infection control. The facility's policy and procedures titled "Linen Handling and Storage" dated 1/2017, indicated all linen is handled, stored, transported, and processed in a manner that prevents contamination.	F 880		