Accepted POC with [redacted] KN, Designee of [redacted]

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

DON 4/17/13 @ 10:40 AM

PRINTED: 04/04/2013
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
	055318	A. BUILDING [redacted] B. WING	03/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 3/18/13 through 3/22/13. The facility was licensed for 253 beds. The census at the time of the survey was 246. The sample size was 30. Representing the California Department of Public Health: 17536, 29259, 29766, and 31388, Health Facilities Evaluator Nurses.	F 000	This Plan of Correction constitutes a written credible allegation of compliance for the deficiencies noted. Preparation and/or execution of this Plan of Correction does not constitute admission in agreement or by the provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. This plan of correction is prepared and / or executed solely because required by provisions of Federal and State Law.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 30 sampled resident's (20) right to be free from a physical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Resident 20 was to be restrained with a seatbelt only when he was transported in a motor vehicle to the dialysis center during a dialysis day. The resident was not to be restrained during a non-dialysis day. Findings: The assessment form Minimum Data Set (MDS) dated 1/8/13 indicated Resident 20 was severely	F 221	Corrective Action-One on One in-service was done with assigned C.N.A on 3/20/2013 Regarding use of restraint and protocol. Rehab evaluation was done on 3/26/2013 regarding diagnosis for use. Resident will be continued with seat belt application during dialysis days due to fall Incident. Other Residents- Residents with orders for restraints such as seat belts were reviewed on 3/26/2013 by Interdisciplinary Team on. No other issues were identified pertaining to restraints. Newly admitted/Readmitted residents with restraints, charts will be reviewed during daily morning meeting for proper assessment and indication of use. Pre-restraining assessment will be	4/23/2013

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
APR 16 2013
L & C DIVISION SAN JOSE

LABORATORY DIREC[redacted] RE | TITLE ADMINISTRATOR | (X6) DATE APRIL 16, 2013

Any deficiency state[redacted] e institution may be excused from correcting providing it is determined that other safeguards pr[redacted] 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 221	Continued From page 1 impaired in cognition, had no behavior issues, and required total assistance in all his activities of daily living. Resident 20 was coded in section G0300A of the 1/8/13 MDS as an "8" when moving from a seated to a standing position, meaning the resident did not move from seated to standing position as observed by the assessment staff. During the survey, observations of the resident while he was seated in his wheelchair confirmed the resident sat still and was not restless. Resident 20 had a physician's order dated 12/9/11 for dialysis (a treatment for individuals with kidneys that no longer perform the normal functions of filtering and removing excess wastes and water) on Tuesday, Thursday, and Saturday. The resident also had a physician's order dated 4/25/12 for a seatbelt in wheelchair during dialysis transfer. The informed consent for this restraint also indicated seatbelt in wheelchair during dialysis transfer. On 3/20/13 (Wednesday, a non-dialysis day) at 10:45 a.m. Resident 20 was observed restrained with a seatbelt as he sat in his wheelchair near his bed in his room. Certified nurse assistant A (CNAA) was in the room. During an interview on the same date and time, CNA A stated Resident 20 could not remove the seat belt because it was tied behind the wheelchair. CNA A stated he did not know whether Resident 20 had a history of falls or why he had to restrain the resident that day. During an interview on 3/20/13 at 1:45 p.m.	F 221	initiated by the Licensed nurse, which will be reviewed by the Interdisciplinary team. Resident will be assessed for proper diagnosis and behavior that will support the use of device. Alternative device will be tried prior to use of any restraint devices. Least restrctive devices will be attempted prior to extensive restraint device. Based on resident assessment, physician order for restraint will be obtained by Licensed nurse. Informed consent will be obtained by MD as per regulation prior to application of restraint. MD will be responsible to discuss the risk vs. benefits with family. Plan of care will be developed and will be documented on Quartely restraint assessment; IDT notes/Risk notes and weekly risk notes. Resident with restraint will be re-evaluated/screened on Quarterly basis by Rehab staff with efforts to reduce to a least restrictive device or no device. Interdisciplinary team will review resident with restraints on Quarterly basis and to asses if clinically feasible for the resident to have a less restrictive device. Systemic changes- Licensed nurses will be in-serviced on Restraint management and protocol with focus on residents with use of seat belt on 3/20/2013 and 4/10/2013	

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F 221	Continued From page 2 licensed nurse B (LN B), charge nurse, stated she did not know why Resident 20 was restrained. On the same date and time, licensed nurse C (LN C), the station supervisor, overheard the interview, and stated Resident 20 had no history of falls, and should only wear the seatbelt while in his wheelchair when he is transported to the dialysis center. LN B, the infection control nurse, and the evaluator went to the big dining room where activities were being held. During an observation on 3/20/13 at 1:55 p.m. Resident 20 sat still in his wheelchair participating in the activity. LN B reached out to Resident 20's abdomen and felt the seatbelt which restrained the resident. The resident sat in his wheelchair with the restraint from 10:45 a.m. to 1:55 p.m., a period of three hours. During an interview on 3/20/13 at 2:00 p.m. the director of nursing service (DON) was asked whether Resident 20 had a history of wanting to get up from his wheelchair or falling from it. After a thorough search of Resident 20's record the DON stated she could not find a single fall incident to warrant the seat belt restraint during a non-dialysis day.	F 221	Monitoring-Director of Nursing/Designee and Rehab Department manager will be responsible to monitor the process. Medical Record will conduct audit on 3/26/2013 residents with restraint for proper assessment and indication/Diagnosis for use. Findings from Medical Record will ne brought to the facility QA&A meeting monthly until compliance is sustained.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	**Resident 9 Activity Care Plan was reviewed and updated by the Activity Director. Individual Participation Record is current and accurate.** **Resident 14 Activity Care Plan was reviewed and updated by the Activity Director. Individual Participation Record is current and**	04/23/13

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F 248	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and provide individualized activities, in accordance with the comprehensive assessment, to meet the needs of three of 30 sampled residents (9, 14, and 26). Findings: 1. Resident 9's clinical records were reviewed on 3/19/13. His minimum data set (MDS, an assessment tool), dated 1/10/13, indicated his cognitive abilities were moderately impaired, he was developmentally delayed and his vision was moderately impaired. His activities assessment, dated 1/17/13 indicated he had limited verbalization skills and was anxious around crowds and loud noises. He was scheduled to have 1:1 in room activities of aromatherapy and sensory stimulation twice a week. His activity care plan, dated 1/17/13, indicated he was to have 1:1 (one staff with one resident) visits two to three time a week for mental and social stimulation including spiritual activities once a week and volunteer visits once a week. His individual participation record for March 2013 indicated the activities in which he participated in included watching TV and talking. There was no documentation indicating he received aromatherapy or sensory stimulation twice a week or spiritual activities once a week. On 3/20/13, the in room 1:1 activity participation log indicated the volunteer spent fifteen minutes with the resident while he was asleep and left the radio on in the resident's room. During an interview on 3/22/13 at 7:30 a.m. with the assistant activity director (AAD), she reviewed	F 248	**accurate.** **Resident 26 Activity Care Plan was reviewed and updated by the Activity Director. Individual Participation record is current and accurate.** **Activity Director Reviewed residents who are currently with in room visits to ensure activity is being done per Care Plan and is accurately noted in the individual participation record. No other issues noted.** **Activity Consultant and Activity Director gave in-service education to activity staff on 3/22/2013 and 3/25/2013 on " In Room Programming", proper and accurate documentation on the Individual Participation Record for in room visits being logged correctly and correspond to their individual care plan.** **In room visits provided by the activity staff will be monitored regularly by the Activity Director to assure patients are receiving visits that are appropriate for each individual and that care plans are being followed.** **Any findings and trends from the monitoring will be discussed in the QA and meeting monthly with follow up as indicated**	

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F 248	Continued From page 4 Resident 9's activity care plan, individual participation record and activity participation log. She stated he did not receive the aromatherapy, sensory stimulation or spiritual activities described as interventions in the care plan. She did not think spending fifteen minutes with a resident who was asleep qualified as a visit from a volunteer. 2. Resident 14's clinical records were reviewed on 3/18/13. Her MDS, dated 7/21/12 and 1/14/13, indicated she was cognitively intact, had a master's degree and had impairments of her upper and lower extremities, on both sides. Her activities assessment, dated 1/8/13, indicated she was to have 1:1 in room activities of aroma and sensory therapy two to three times a week. Her activity care plan, dated 3/20/13, indicated she was to have 1:1 in room visits two to three times a week for mental and social stimulation, gentle and appropriate touch, music that provided gentle stimulation and individual activities as tolerated. Her individual participation record for March 2013 indicated the activities in which she participated included watching TV, talking and visiting with family. There was no documentation indicating she received aromatherapy or sensory therapy two to three times a week. On 3/6/13, the in room 1:1 activity participation log indicated the volunteer gave the resident's family member a coloring book even though the resident was unable to hold or manipulate a crayon. During an interview on 3/20/13 at 11:00 a.m. with Resident 14's family member, he stated the facility did not provide Resident 14 with any activities.	F 248	**Blank Page**	

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F 248	Continued From page 5 During an interview on 3/22/13 at 7:40 a.m. with activity assistant 1 (AA 1), she reviewed Resident 14's activity care plan, individual participation record and activity participation log. She stated Resident 14 did not receive the aromatherapy or sensory therapy described as interventions in the care plan. She also stated the reading, watching TV, and talking activities were all provided by the family member and not by the activity staff. 3. The clinical record for Resident 26 was reviewed on 3/20/13. Resident 26 was non-verbal. The activity care plan dated 2/25/13 indicated goals for Resident 26 to receive 1:1 room visits 2-3 times a week for mental and social stimulation due to his medical condition. Interventions to offer/provide in room activities as tolerated and desired which include aroma and sensory stimulation. During an interview on 2/21/13 at 2:30 p.m, certified nursing assistant F(CNA F) she stated every morning she used a Hoyer lift (a mechanical lifting device) to get up Resident 26 and wheels him to the lobby where almost everyday he visits with a family member. A review on 3/21/13 of Resident 26's individual participation record (IPR) for the months of February and March, indicated no 1:1 activities were offered from 2/24/13 through 2/28/13 and from 3/1/13 through 3/5/13 and 3/12/13 through 3/18/13. Resident 26 was in the acute hospital from 2/17/13 through 2/21/13 and 3/6/13 through 3/11/13. During an interview on 3/22/13 at 7:40 a.m., the AAD stated Resident 26 was placed on 1:1 in	F 248	**Blank Page**	

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F 248	Continued From page 6 room visits on 2/25/13. She also stated activities for 1:1 in room visits included hand massages with lotion, aromatherapy, and other activities to suit Resident 26's interest, like music and religious activities. AA 1 reviewed the IPR for February and March and validated no 1:1 in room activities were offered to Resident 26 during the above-listed time period. During an interview on 3/22/13 at 9:45 a.m., the AA 1 stated Resident 26 was often seen in the lobby visiting with a family member. This was documented in the IPR under talking/conversing, visit with family and relaxation. AA 1 also stated documentation under talking/conversing was inaccurate since Resident 26 was aphasic (unable to speak).	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a sanitary environment in one of 12 showers when a green substance was observed smeared on the shower curtain in shower room number six. Unsanitary resident showers may have a potential to spread disease. Findings: During an observation on 3/20/13 at 3 p.m. the shower curtain in shower room six had a green smear of an unknown substance approximately	F 253	Shower Curtain in shower room 6 was immediately replaced by housekeeping Department. Environmental Services Manager conducted rounds throughout resident bathrooms and shower rooms to ensure cleanliness is being maintained with no dirt build up on shower curtains Environmental Services Manager gave in-service education on 3-23-13 to the housekeepers to check shower curtains for any substance build up or dirt build up and if there is, it needs to be replaced immediately Nursing Management Team and Department heads will do Ambassador rounds to include the shower curtains	4-23-2013

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F 253	Continued From page 7 one and one-half inches in diameter. During the environmental tour on 3/21/13 at 7:50 a.m. the shower curtain in shower room six had a green smear of substance approximately one and one-half inches in diameter. During an interview on the same day and time, the maintenance supervisor stated the shower curtain should not be dirty like that and should be changed. On 3/21/13 at 2:55 p.m. the policy "Cleaning & Disinfecting Bathing Tubs & Showers", dated 11/15/02, did not indicate a procedure for ensuring shower curtains were maintained in a sanitary condition.	F 253	from the shower rooms to ensure cleanliness. Any findings during the ambassador rounds will be reported in the Daily Morning Meeting Findings and Trends from the Daily Morning meeting will be discussed in the Monthly QA and A until sustained.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement activity care plans for three of 30 sampled residents (9, 14 and 26). For Residents 9, 14 and 26, the facility failed to implement one-on-one (one staff with one resident (1:1)) in room activity care plans for mental, social and sensory stimulation. Findings: 1. Resident 9's clinical records were reviewed on 3/19/13. His activity care plan, dated 1/17/13,	F 282	Resident 9,14 and 26 care plan for 1:1 activity was put in place on March 29, 2013 Resident 9 individual participation log on March 29, 2013 indicated that Resident start receiving aromatherapy, sensory stimulation and spiritual activities once a week as documented on the care plan. Resident 14 individual participation log on March 29, 2013 indicated that Resident start receiving aromatherapy, sensory stimulation once a week as documented on the care plan. Resident 26 individual participation log on March 29, 2013 indicated that Resident start receiving aromatherapy, sensory stimulation once a week as	4/23/2013

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F 282	Continued From page 8 indicated he was to have 1:1 visits two to three time a week for mental and social stimulation including spiritual activities once a week and volunteer visits once a week. His individual participation record for March 2013 indicated the activities he participated in included watching TV and talking. There was no documentation indicating he received aromatherapy or sensory stimulation twice a week or spiritual activities once a week. On 3/20/13, the in room 1:1 activity participation log indicated the volunteer spent fifteen minutes with the resident while he was asleep and left the radio on in the resident's room. During an interview on 3/22/13 at 7:30 a.m. with the assistant activity director (AAD), she reviewed Resident 9's activity care plan, individual participation record and activity participation log. She stated he did not receive the aromatherapy, sensory stimulation or spiritual activities described as interventions in the care plan. She did not think spending fifteen minutes with a resident who was asleep qualified as a visit from a volunteer. 2. Resident 14's clinical records were reviewed on 3/18/13. Her activity care plan, dated 3/20/13, indicated she was to have 1:1 in room visits two to three times a week for mental and social stimulation, gentle and appropriate touch, music that provided gentle stimulation and individual activities as tolerated. Her individual participation record for March 2013 indicated the activities in which she participated included watching TV and talking and visiting with family. There was no documentation indicating she received aromatherapy or sensory therapy two to three	F 282	documented on the care plan. Other Residents- Activity care plans and individual participation logs for residents with 1:1 room activities were audited on March 29, 2013 No other issues identified pertaining to activity care plan and individual participation log for residents with 1:1 room visits. Newly admitted or Readmitted residents charts will be reviewed during daily morning meeting to ensure that residents with physician order for activities with focus on residents whom will require 1:1 room visits, their individual participation log will be initiated and completed as per regulation. Plan of care will be updated accordingly to reflect resident's needs for activities. 1:1 in-service was done by an Administrator with Activity Director and Activity assistants on April 1, 2013 with focus on completion of residents with 1:1 activities, their individual participation log and care plans. Administrator will be responsible to monitored to monitor the process. Medical Record will conduct audit on Activity care plans, residents with 1:1 activities, required individual participation log on monthly basis and care plans. Any negative findings	

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F 282	Continued From page 9 times a week. During an interview on 3/20/13 at 11:00 a.m. with Resident 14's family member, he stated the facility did not provide Resident 14 with any activities. During an interview on 3/22/13 at 7:40 a.m. with activity assistant 1 (AA 1), she reviewed Resident 14's activity care plan, individual participation record and activity participation log. She stated Resident 14 did not receive the aromatherapy or sensory therapy described as interventions in the care plan. She also stated the reading, watching TV, and talking activities were all provided by the family member and not by the activity staff. 3. The clinical record for Resident 26 was reviewed on 3/20/13. Resident 26 was non-verbal. The activity care plan dated 2/25/13 indicated goals for Resident 26 to receive 1:1 in room visits two to three times a week for mental and social stimulation due to his medical condition. Interventions to offer/provide in room activities as tolerated and desired which included aroma and sensory stimulation. Review on 3/21/13 of Resident 26's individual participation record (IPR) for the months of February and March, indicated no documentation of 1:1 in room activities including aromatherapy and sensory stimulation were offered to Resident 26 from 2/24/13 through 2/28/13 and from 3/1/13 to 3/5/13 and 3/12/13 to 3/18/13. During an interview on 3/22/13 at 7:40 a.m. the AAD stated Resident 26 was care planned to have 1:1 in room visits on 2/25/13 after Resident	F 282	from chart reviews from morning meeting and Medical record audits will be brought to the Facility monthly QA&A meeting until compliance is sustained.	

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F 282	Continued From page 10 26 returned from the acute hospital. The IPR for February and March were reviewed by AAD and confirmed 1:1 in room visits were not offered since the care plan was developed.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an environment free from accident hazards as evidenced by seven empty, size E, oxygen tanks observed in a storage closet standing alone and unsecured. Three used disposable razors were observed in shower room number four; one in the regular trash container on the wall and two on top of the sharps container. There may be a potential for resident injury from unsecured oxygen tanks and improperly disposed of sharps. Findings: During the initial tour on 3/18/13 at 12:50 p.m. seven empty, size E, oxygen tanks were observed in a storage closet standing alone and unsecured. During an interview on the same day and time licensed nurse D (LN D) stated the seven tanks should have been secured by chains to prevent	F 323	The seven unsecured empty E tanks oxygen containers in oxygen closet were immediately secured and chained when the issue was noted. All razors found outside the sharp containers in shower room number four were immediately disposed off during the environmental tour. The Maintenance Director conducted facility rounds to ensure there were no oxygen tanks unchained and freely standing and also checked all shower rooms to ensure that all razors are secured inside the sharp containers located in the shower rooms. No other issues noted. The Director of Staff Development conducted in-service education on 3/23/2013 with the Nursing staff and Central Supply Director regarding securing oxygen containers at all times and to make sure that all razors are contained in the sharp container inside the shower room after use at all times. Department Managers and the Nursing Management team will continue to conduct Ambassador rounds daily with a focus on ensuring	4-23-2013

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	055318	A. BUILDING _____ B. WING _____	03/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

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F 323	Continued From page 11 them from falling. During the environmental tour on 3/21/13 at 7:50 a.m. shower room number four was observed to have one used, uncovered disposable razor in the trash container on the wall and two used, uncovered disposable razors on top of the sharps container on the wall. During an interview on the same day and time the maintenance supervisor stated the razors should have been disposed of in the sharps container so that residents would not accidently be harmed. On 3/22/13 a review of the facility policy "Oxygen Storage & Assembly", dated 8/15/02, indicated to secure each tank individually, by a chain, on a cart, or on a stand. On 3/22/13 a review of the facility policy "Wastes & Cleaning Practices", dated 11/15/02, indicated to "place contaminated sharps in appropriate containers immediately, or as soon as possible, after use".	F 323	that the oxygen canisters are secured properly and razors in the shower rooms are properly disposed inside the sharp containers with follow-up as indicated. Findings of Ambassador rounds are discussed daily during the Morning Stand-up meeting. Findings and trends identified during Ambassador rounds with regards to unsecured oxygen canister and razors not properly disposed off inside the sharp container will be reviewed by the QA&A Committee monthly with follow-up as indicated.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. All the food that were undated, unlabeled, and expired that was found in the walk in refrigerator were all disposed off in the garbage. No other issues noted 2. All the food that were undated and unlabeled found in the walk in freezer were all disposed off in the garbage. No other issues noted. 3. All the food that were undated and unlabeled found in the dry storage were all disposed off in the garbage.	4/23/2013

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F 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store food under sanitary conditions. Findings: During the initial tour on 3/18/13 at 7:40 a.m. and accompanied by the assistant dietary manager (ADM), the following were observed: 1. The walk-in refrigerator contained six undated individual pizzas, two undated 12 packages of hamburger buns, three undated bags of scrambled eggs, one bag of undated and unlabeled "Tator Tots", and one bag of expired sausages dated 3/7/13. 2. The walk-in freezer contained one undated bag of potatoes, one undated and unlabeled bag of Tator Tots, and one undated and unlabeled bag of chicken thighs and legs. 3. The dry storage contained one undated bag of cherry gelatin, one undated and unlabeled bag of macaroni, and one expired bag of Rice Crispies dated 2/20/12. 4. The kitchen contained one undated and unlabeled bin of brown sugar. During a concurrent interview with the ADM, she stated all food items should be labeled and dated. A review of the facility's "Food Storage Principles Policy", dated 4/15/01, indicated "[l]abel each package, box, can, etc. with the expiration date, date of receipt, or when the item was stored after preparation...Discard foods that have exceeded	F 371	No other issues noted. 4. The brown sugar that was undated and unlabeled found in the kitchen was disposed off in the garbage. No other issues noted. The Dietary Manager double check all areas of the kitchen to ensure all food are labeled and dated in the walk in freezer, walk in refrigerator, and dry storage. No other issues noted. The Dietary Manager conducted a review of food labeling and dating in the Dietary Department. No other issues were noted. Dietary personnel were given in-service education by the Registered dietician on March 21, 2013 on proper labeling, dating and discarding food from walk in refrigerator, walk in freezer, Dry storage, and the Kitchen. Dietary Manager or Designee will monitor the labeling, dating, and discarding of food products daily and to ensure that there are no expired food items found in the kitchen. All findings from the monitoring will be reported in the Daily Stand Up meeting. The findings and trends identified during the morning meeting in regards to labeling, dating, and discarding of expired food will be discussed by the QA&A Committee monthly times three months or until sustained.	

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F 371	Continued From page 13 their expiration date."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Corrective Action- Room 601 and 60B shared bathroom, wash basins were labeled on3/18/2013 Room 603 and 604 shared bathroom, wash basins were labeled on 3/18/2013 Room 615 and 614 wash basin, emesis basin and water pitcher were labeled on 3/18/2013 Room 515 and Room 516 wash basins were labeled on 3/18/2013 Other Residents- Room rounds were conducted on 3/18/2013 by Department heads. Disposable resident care items were labeled on 3/18/2013 No other issues were identified. Ambassador rounds will be conducted daily by Department heads with focus on Labeling of residents disposable items. Any issues or items not labeled will be brought to the daily morning meeting for follow up and items will be labeled immediately as issue identified. Corrections/Findings will be documented in Ambassador round sheet on daily basis. All staff in-service was done on 3/20/2013 and 4/10/2013 regarding	4/23/2013

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F 441	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow infection control procedures when personal care equipment was observed unlabeled in four shared bathrooms. Findings: During the initial tour on 3/18/13 at 8:20 a.m. and accompanied by licensed nurse E (LN E), the following were observed: 1. Two unlabeled wash basins in the shared bathroom between Room 601 and Room 602; 2. An unlabeled wash basin and an unlabeled bed pan in the shared bathroom between Room 603 and Room 604; 3. An unlabeled wash basin, an unlabeled emesis basin and an unlabeled water pitcher in the shared bathroom between Room 614 and Room 615; and 4. An unlabeled wash basin between Room 515 and Room 516. During a concurrent interview with LN E, she stated all personal items should be labeled with the owner's name to prevent use by the wrong resident and potential infection. A review of the facility's "Disposable Resident Care Items Policy", dated 11/15/02, indicated "[e]nsure that multiple-use disposable items are	F 441	Resident disposable items labeling and storage. Infection control nurse and Director of nursing will ne responsible to monitor the process. Infection control nurse will be responsible to do through facility rounds once a week to ensure that resident's disposable items has been labeled. Any findings from rounds form Ambassador rounds and Infection control nurse will be brought to facility Monthly QA&A meeting until compliance is sustained.	

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F 441	Continued From page 15 easily identified as belonging to the resident using the items: by labeling with the resident's name..."	F 441		
F 458 SS=C	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: Based on observation, interview and record review, the following multi-resident rooms provided less than 80 square feet per resident. Findings: Room Number — Sq. ft. per bed 1. 108 and 109 — 73.3 2. 114, 115, 210, 211 — 74.0 3. 314,315,316,317,403 201 through 208 — 74.7 4. 110,111,112,217,218 219,220 — 76.0 5. 301 and 302 — 68.0 6. 303 — 70.3 7. 116,117,308 — 75.5 8. 309,310 — 73.7 9. 311,312,619 — 74.5 10. 404,405,406,409, 501 through 509 — 75.7 11. 407,408 — 73.5 12. 411,412,414,415 through 419 — 76.5 13. 510,511,515,516 — 75.3 14. 512,514,601,602, 614,615 — 77.5	F 458	**Residents verbalized no complaints or concerns regarding space or privacy. Nursing Services were not impacted by the shortage of space. The closet and storage space were sufficient to accommodate the needs of the residents.** **On a regular basis, Social Services and Ambassadors do rounds and ask residents if there are any problems or issues with the lack of space or privacy and they indicate no verbalizations of complaints and concerns.** **Social Services and or designee shall be responsible for monitoring. Any concerns shall be discussed at the morning meeting and the monthly QA and A meetings.**	04/23/13

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F 458	Continued From page 16 15. 603,604 77.0 16. 609,610,611,612 76.3 During the survey, interviews were conducted to determine if there were any problems or issues with the lack of space or privacy. Residents verbalized no complaints or concerns regarding space or privacy. The residents were observed in their rooms throughout the survey. The nursing care and services were not impacted by the shortage of space. The closet and storage spaces were sufficient to accommodate the needs of the residents. Recommend the waiver remain in place.	F 458	**Blank Page**	