STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056080	A. BUILDING _____ B. WING _____	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLINDA IMPERIAL CONV HOSP	150 BELLEFONTAINE PAS PASADENA, CA 91105

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: Surveyor ID: 14430 Surveyor ID :28074 Surveyor ID: 27785 Surveyor ID: 30258 Surveyor ID: 16279 Total Resident Population: 100 Total Resident sample: 20 Highest Scope and Severity: E	F 000	This Plan of Correction is provided pursuant to California Health and Safety Code, Section 1280. It is prepared and/or executed solely because the provisions of Federal and State laws require it. It is Marlinda Imperial Convalescent Hospital's written credible allegation of compliance for the deficiencies noted during the standard survey conducted by the CDPH Health Facilities Division surveyors completed on July 13, 2012.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to treat one out of 20 sampled residents (Resident 15), and five of 11 residents who attended the group interview with dignity and respect by ensuring that the staff did not speak in a different language other than English while providing care. This resulted in the residents being bothered and annoyed because they did not know what the staff were saying and if they	F 241		

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HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Evangeline H. Malubay
TITLE: Administrator
DATE: 10/8/12

(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 241	Continued From page 1 were talking about them. Findings: a. During an interview with Resident 15 on 7/12/12 at 3:30 p.m., she stated that she had experienced staff speaking in a different language other than English among themselves inside her room while providing care. Resident 15 said this bothers her and is annoying because she could not understand what the staff were saying and did not know if the staff were talking about the residents. The resident further stated that it was brought up during the previous resident council meeting and the staff were aware of staff speaking in a different language inside her room while providing care, but the concern still continued to be a problem. The clinical record for Resident 15 was reviewed on 7/12/12. The admission record (face sheet) indicated Resident 15 was originally admitted to the facility on 4/23/01, and was readmitted on 2/22/09 with diagnoses of type II diabetes mellitus (a disease in which there are high levels of sugar in the blood), hypertension (high blood pressure), and coronary artery disease (a narrowing of the small blood vessels that supply blood and oxygen to the heart). The most recent minimum data set (MDS), a standardized assessment and care planning tool, dated 5/26/12, indicated Resident 15 had the ability to understand others and to make herself understood. She was oriented to the year, month, and day, and did not have any mood or behavioral problem. Resident can independently	F 241	F 241 * In-service was given to all staff on 7/16/12, regarding the Policy on "Spoken Language in Facility." Emphasized to them the importance of speaking English in resident care areas, except when resident's primary language is the same as that of the care-giver, and resident is comfortable communicating in their common language. * All 100 residents in the facility at the time of survey had the potential of being affected by this deficient practice. In-service was provided to all staff. Administrator and DON attended the Resident Council Meeting on 7/27/12, where they explained to the residents the existing facility policy on "spoken language" in the facility. Residents in attendance were also asked to help administration enforce this policy by calling the attention of the staff whenever they speak a language other than English in	

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F 241	Continued From page 2 transfer from her bed to a wheelchair but needs extensive assistance from staff for dressing and toileting. A review of the facility's policy and procedure dated March 2006, titled "Spoken Language in Facility", indicated that it is the policy of this facility to speak English in resident areas and work areas except if resident's primary language is the same as that of the caregiver. The policy also indicated that department heads and supervisors are responsible for enforcement by advising, monitoring, and by issuing warnings and disciplinary write-ups when necessary. During an interview with the director of nursing (DON) on 7/13/12 at 11:15 a.m., she stated that she was aware of the staff speaking in a foreign language in the presence of the residents as it was brought up once during a resident council meeting. The DON said that staff in-services were done regarding this issue and she was not aware that it was an ongoing problem. The DON said that the staff are not supposed to speak any language other than English when in the presence of residents or in the work areas. b. During a group interview on 7/12/12 at 10:00 a.m., five of 11 residents who attended the meeting stated that some of the staff speak in a different language other than English while at the nurse station, in the hallways, and even inside their room. The residents stated that this occurs on all shifts and staff speaking in a different language other than English bothers them, especially when the staff are in their room providing care for them, because the residents did not know if the staff were talking about them.	F 241	Cont'd. F 241 areas where they are not supposed to. * To ensure this deficient practice does not recur, in-services regarding this policy will be given to all staff on a quarterly basis. Department Heads and Supervisors are made responsible in enforcing this policy by monitoring, advising, and issuing of warnings and disciplinary write-ups when necessary, as stated in the policy. * DSD and Supervisors on all shifts will monitor while doing their daily rounds. DON and Administrator will monitor that corrective measure put in place is achieved and sustained through weekly IDT meetings. Continued issues on this matter will be discussed at the quarterly meeting of the QA Committee.	

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F 241	Continued From page 3 They further stated that they have brought this concern to the staff's attention and the concern was brought up during previous resident council meetings, but staff speaking in a different language other than English was not resolved and continued to occur. A review of the facility's policy and procedure dated March 2006, titled "Spoken Language in Facility", indicated that it is the policy of this facility to speak English in resident areas and work areas except if resident's primary language is the same as that of the caregiver. The policy also indicated that department heads and supervisors are responsible for enforcement by advising, monitoring, and by issuing warnings and disciplinary write-ups when necessary. During an interview with the director of nursing (DON) on 7/13/12, at 11:15 a.m., she stated that she was aware of the staff speaking in a foreign language in the presence of the residents as it was brought up once during a resident council meeting. The DON said that staff in-services were done regarding this issue and she was not aware that it is an ongoing problem. The DON said that staff are not supposed to speak any language other than English when in the presence of residents or in the work areas.	F 241	Cont'd. F 241 * Corrective measures have been put in place and implemented by 7/16/12.	7/16/12
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		

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F 248	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial well - being of 1 of 20 sample residents (14). The facility did not offer activities for a resident who required isolation. Findings: On July 11, 2012 between 9 a.m. and 10 a.m., Resident 14 was observed sitting in the wheelchair inside his room. Resident 14 told the Surveyor, "Oh, I can't wait to get out of this room. I would like to do something out there, or may be if they can only give me something to do here, look at me there's nothing got do here but stare outside the door." The resident then stated, " they told me I can't go out of my room because I have some kind of infection." A review of the Admissions Face Sheet revealed Resident 14 was admitted to the facility on July 4, 2012. The admission orders indicated that Resident 14 had a diagnosis of end stage chronic obstructive pulmonary disease (one of the most common lung diseases where it makes it difficult to breathe). Further review of the clinical records also revealed that the resident was placed on respiratory isolation for Methicillin-resistant Staphylococcus aureus (MRSA- is a type of bacteria that causes infections in different parts of the body that is tougher to treat than most strains bacteria because it is resistant to some commonly used antibiotics.)	F 248	F 248 * The Activity Director completed the assessment of resident 14 on 7/10/12. The Policy and Procedure on Admission Assessment was revised and approved by the QA Committee during its quarterly meeting on 7/11/12. The revised policy states that the initial assessment and interview of residents by Activity Dept., Dietary Dept., and Social Services Dept. will be made within 72 hours of resident's admission. Completion of specific MDS sections for the above departments is based on the MDS 3.0 guidelines. Resident 14 was provided a radio on 7/11/12, which was set to his favorite country western music station. A flat-screen television was installed in resident 14's room on 7/12/12. * Medical Records staff audited charts of recently admitted residents. Required assessments were in place. One-on-one in-	

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F 248	Continued From page 5 Another interview was conducted with Resident 14 on July 11, 2012 at 11 a.m. Resident 14 stated, "I wish I have a television or radio here. They offered me some books and magazines, but I can't read. They come here every morning but that's about it. Nothing to do afterwards." The resident's care plan was reviewed with the activity director on July 11, 2012 at 12 p.m. The activity director stated that she had not done the resident's activity assessment since the admission on July 4, 2012. The activity director further stated that she had 14 days to complete the assessment. There was also no care plan for activities and interests for Resident 14 especially or for any residents who were isolated or after the morning activities were provided by the activity department. However, the activity director stated that the activity staff had come to the resident's room daily and provided some activities for the resident. The activity director also stated that the residents who were admitted in the West Nursing Station were not provided any television set by the facility. The activity director stated that the facility would ask the resident's family to bring their own television. With regards to Resident 14, the activity director was aware that he does not have any family and she did not know who would bring in a television set for the resident. A review of the facility's undated activity program policy and procedure revealed that, "Our activity program is designed to encourage restoration to self care and maintenance of normal activity which is geared to the individual resident's needs. Our activity program is designed to meet the needs of each residents. The Activity Program	F 248	Cont'd. F 248 service was provided to the Activity Director on 7/17/12 regarding this revised policy. * The Policy and Procedure on Admission Assessment was revised and approved by the QA Committee during its quarterly meeting on 7/11/12. The revised policy states that the initial assessment and interview of residents by Activity Dept., Dietary Dept., and Social Services Dept. will be made within 72 hours of resident's admission. Completion of specific MDS sections for the above departments is based on the MDS 3.0 guidelines. Medical Records staff will audit charts of residents within 48 hours of admission, to capture any discrepancies and notify involved departments immediately for absence of required assessments, and will have the opportunity to complete it within 72 hours according to facility's policy.	

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F 248	Continued From page 6 consists of individual, and small and large group activities which is designed to meet the needs and interest of each resident that includes-room activities."	F 248	Cont'd. F 248 * Audit reports are submitted to the Administrator to allow her to monitor that the systemic changes put in place is achieved and sustained, to ensure the deficient practice does not recur. Any continuing discrepancies will be discussed at the quarterly meeting of the QA Committee. * Corrective action is put in place and will be fully implemented by August 5, 2012.	8/5/12
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that residents with indwelling urinary catheter were adequately monitored to prevent urinary tract infections and to ensure the catheters were securely anchored (secured) to prevent pain and ensure the catheters did not become accidentally dislodged for 4 out of 5 residents with indwelling catheters out of 20 sampled residents (Residents 10, 11, 16, and 1). The tubing to Resident 10's urinary catheter was observed with cloudy urine, large amounts of sediment, and moderate amounts of blood. Resident 10, 11, and 16's urinary catheters were not secured. Resident 1 urinary catheter was observed with moderate amounts of sediment.	F 315	F 315 * (a) MD was notified on 7/12/12 of Resident 10's change of condition re: observation with large amount of sediments,	

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F 315	Continued From page 7 This had the potential to result in untreated urinary tract infections as well as injuries of the urethra, including urethral tears. Findings: a. On July 10, 2012 at approximately 9:15 a.m., during the initial tour with licensed vocational nurse (LVN) 2, the tubing to Resident 10's urinary catheter was observed with large amounts of sediment and cloudy urine. Sediments and cloudy urine were also observed in the tubing of the urinary catheter on July 11, 2012. On July 12, 2012, at 7:20 a.m., the tubing and bag to the resident's urinary catheter was observed with moderate amounts of blood tinged urine and sediments. At the same time, the surveyor notified the staff. Also the resident's urinary catheter was not strapped (secured) to the resident's leg. There was no indication in the facility's documentation the staff had notified the physician of the cloudy urine with sediments that had been observed on July 10, and July 11, 2012, nor of the blood tinged urine with sediments observed on July 12, 2012. Review of an "Admission Face Sheet", indicated Resident 10 was admitted to the facility on July 6, 2012. The resident's diagnoses included urinary retention, chronic obstructive pulmonary disease (COPD), refers to a group of lung diseases that block airflow during exhalation making it increasingly difficult to breathe. Review of an untitled care plan dated July 6, 2012, indicated as a problem that the resident had the potential for infection related to the use of a urinary catheter, (a flexible tube that is passed	F 315	Cont'd. F 315 cloudy urine and moderate amount of blood on catheter tubing. Nurse Practitioner from MD's office came the same day, and examined Resident 10. MD ordered to flush F/C with 60 cc NS Q 4° PRN until clear X 72°, and check U/A in A.M. (7/13/12). Monitoring for presence of sediments and blood in F/C tubing/bag Q 4° X 72° was also ordered, and call MD for any change in condition. On 7/13/12 MD changed the order for flushing to irrigate F/C until clear Q 2° PRN. Levaquin 500 mg via GT QD X 5 days for re-occurrence of UTI,was also ordered. On 7/13/12 a leg strap was applied to Resident 10's right leg to secure the catheter tubing. One-on-one in-service was given to the treatment nurses on 7/13/12 regarding the importance of applying leg strap for all residents with indwelling urinary catheter to prevent dislodgement or trauma. DON gave one-on-one in-service to RN Supervisor &	

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F 315	Continued From page 8 through the urethra into the bladder to help drain urine [indwelling urinary catheter]). The care plan interventions included to observe the urine for dark color, foul odor, and cloudy appearance and report. In an interview on July 12, 2012 at 7:55 a.m., licensed vocational nurse (LVN)3 was asked if he was aware the resident's urinary catheter had moderate amounts of blood tinged urine, both in the catheter tubing as well as in the urinary collection bag. The LVN stated he was not aware there was any blood in the resident's catheter and also stated he had received report from the night nurse who had not mentioned anything about the urine in the catheter. In another interview on July 12, 2012 at 8 a.m., LVN 2 was asked if it was normal for urine to be blood tinged with sediments. LVN 2 stated, "No". The LVN was asked if the physician had been notified about the cloudy urine and sediments observed in the resident's catheter on July 10 and 11, 2012. LVN 2 stated the physician had not been notified. The LVN was asked what should be done when there is presence of blood and sediments in the urine. LVN 2 stated the physician should be notified. On July 12, 2012 at 8:45 a.m., in an interview, the director of nursing (DON) stated it is the responsibility of the licensed nurse to notify the registered nurse (RN) supervisor if any sediments are observed in a resident's indwelling urinary catheter. The DON stated indwelling catheters should be monitored by the licensed nurses. Review of the undated policy titled, "Catheter	F 315	Cont'd. F 315 charge nurse assigned to the West Station on 7/13/12 regarding importance of making rounds and prompt notification of MD for any change in resident's condition. The policy and procedure on urinary catheter care was also reviewed with RN Supervisor & charge nurse. A care plan for F/C was updated. Adding to intervention was secure F/C with leg strap to urinary catheter tubing to prevent dislodgment or trauma. (b & c) Leg strap was applied to Residents 16's & 11's right leg on 7/13/12, to secure the catheter tubing. One-on-one in-service was provided to the treatment nurses on 7/13/12 about the importance of applying leg strap for all residents with indwelling urinary catheter, to prevent dislodgement and trauma. DON gave one-on-one in-service to RN Supervisor &	

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F 315	Continued From page 9 (Indwelling), Insertion and Removal of (Female and Male)", indicted as general documentation guidelines: date, time procedure, amount of urine obtained, color, consistence, odor, presence of blood, pus or anything unusual. b. On July 12, 2012 at 10:35 a.m., Resident 16 was observed lying in bed, the residents urinary catheter was observed unsecured. Review of an, "Admission Face Sheet", indicated Resident 16 was admitted to the facility on July 3, 2012. The resident's diagnoses included atrial fibrillation and chronic obstructive pulmonary disease ([COPD] refers to a group of lung diseases that block airflow during exhalation making it increasingly difficult to breathe). Review of the residents"Admitting Orders", indicated the resident was to have a urinary catheter size FR 16 with a five milliliter balloon, for bladder retention. In an interview on July 12, 2012 at 11:20 a.m., Resident 16 was asked if he ever feels any discomfort from the urinary catheter. The resident stated the catheter sometimes "Tugs" when he is being moved. c. On July 11, 2012 at 3:50 p.m. the resident was observed in bed sitting up. In the presence of certified nursing assistant 1 (CNA 1) the tubing from the resident's urinary catheter was observed coiled under the resident's right buttock and leg, there was no strap securing the urinary catheter to the resident's leg. Review of an, "Admissions Face Sheet", indicated Resident 11 was admitted to the facility on September 9, 2002, and was re-admitted on	F 315	Cont'd. F 315 charge nurse assigned to the East Station on 7/13/12 regarding importance of making rounds and prompt notification of MD for any change in resident's condition. The policy and procedure on urinary catheter care was also reviewed with RN Supervisor & charge nurse. In-service given to all nursing staff (licensed and CNAs) about the policy and procedure for taking care of resident on indwelling urinary catheter; addressing with the attending physician any signs and symptoms of UTI or any changes in condition pertaining to catheter care; and promptly reporting of lab work results that may warrant physician's attention. (d) On 7/12/12 at 10:40 a.m., MD ordered a clarification of F/C order for Resident 1 as follows:	

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F 315	Continued From page 10 April 4, 2012. The resident's diagnoses included dysphagia (difficulty swallowing) and diabetes (a chronic disease in which high levels of glucose (sugar) build up in the blood stream. Review of a Minimum Data Set (MDS), a standardized assessment and care screening tool, dated April 17, 2012, indicated the resident was totally dependent on staff for bed mobility and dressing and required extensive assistance with eating and personal hygiene. Review of a physician's order dated April 4, 2012, indicated the resident was to have a urinary catheter size FR 18 with a 15 milliliter balloon for neurogenic bladder (dysfunction of the urinary bladder due to disease of the central nervous system). Review of the form, "Braden Scale-For Predicting Pressure Sore Risk", dated April 17, 2012, indicated the resident was at high risk for the development of a pressure sore. Review of the care plan titled, "Skin Integrity Impairment", dated June 9, 2012, indicated the resident had a re-occurrence of right buttock redness. The care plan intervention included to assess factors that have led to the development of skin integrity impairment. In an interview on July 13,2012 at 9:25 a.m., registered nurse (RN)2 was asked how the facility prevents injury from occurring to residents with indwelling catheters such as catheters accidentally become dislodged. RN 2 stated charge nurses are required to monitor and check all residents with indwelling catheters. The RN	F 315	Cont'd. F 315 - F/C F#16 with 5 cc balloon to continuous drainage bag. - Change F/C and drainage bag QD X 30 days and PRN (occluded, leaking or dislodged). - Irrigate F/C with 50 cc NS QD and PRN (occluded or excessive sediments). - Monitor for increased presence of sediments and blood in the catheter tubings Q 4° X 72°. - Call MD/hospice for any significant change of condition. All above orders were carried out. DON gave one-on-one in-service to RN Supervisor & charge nurse assigned to the West Station on 7/13/12 regarding importance of making rounds and prompt notification of MD for any change in resident's condition. The policy and procedure on urinary catheter care was also reviewed with RN Supervisor & charge nurse.	

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MARLINDA IMPERIAL CONV HOSP	150 BELLEFONTAINE PASADENA, CA 91105

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F 315	Continued From page 11 was asked if any of the residents with indwelling urinary catheters have any type of leg strap to secure the catheter from accidentally becoming dislodged. The RN stated none of the residents with indwelling catheters have leg straps to secure the catheters. Unsecured catheter can lead to bleeding, trauma, pressure sores, penile erosion and bladder spasm from pressure and traction. Securement devices stabilize that catheter and prevent tension and drag, thus reducing friction and trauma within the urethra and the bladder. It is recommended that the catheter be secured to the thigh for women and to the upper thigh or lower abdomen for men. The lower abdomen or upper thigh position in men gently curves the penis up and to the side and decreases the potential for pressure necrosis and urethral erosion at the penile-scrotal junction. (Swearingen, Pamela L Current concept in catheter management). d. Resident 1 was admitted to the facility on 5/26/12, with diagnoses that included acute renal failure (rapid loss of kidney function), atrial fibrillation (irregular heart beat) and lump in the breast according to admission face sheet. The resident was admitted with an indwelling urinary catheter for pain management and was under the care of hospice. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 6/5/12, indicated the resident had short and long term memory recall problem and was totally dependent in activities of daily living. On 7/101/12 at 8:15 a.m., an initial tour of the facility was conducted with the Registered Nurse	F 315	Cont'd. F 315 * All other residents with urinary catheter were re-assessed and visual rounds made. Drainage was free of blood or any signs and symptoms of infection, and leg straps were in place. All nursing staff was given in-service on 7/16/12 re: policy and procedure on how to care for residents on indwelling urinary catheter. * RN Supervisor and charge nurses will continue to perform regular visual rounds during their shift to ensure the residents' condition are well monitored and proper intervention is provided. Change of shift endorsement will be continue to be done between the outgoing and incoming nursing staff. CNAs were in-serviced to report promptly any changes in residents' condition to the licensed nurse to allow them to re-assess the condition of the resident and provide necessary	

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F 315	Continued From page 12 (RN) Supervisor 1 . The resident was observed asleep in bed. The resident had an indwelling urinary collection bag that contained 75 cubic centimeter of slightly cloudy, yellow urine with moderate amount of urine sediments in the urinary tubing. Further observations on 7/11/12 at 2:40 p.m., and on 7/12/12 at 8:05 a.m., the resident's urinary tubing was observed with moderate amount of slightly cloudy, yellow urine with sediments. A review of the plan of care dated 5/26/12, indicated Resident 1 was assessed as having the potential for urinary tract infection (UTI) related to the use of an indwelling urinary catheter. The plan of care interventions dated 5/26/12, indicated the resident's urine was to be monitored for signs and symptoms of UTI such as dark color, foul odor, cloudy appearance and to notify the hospice physician. A review of the licensed nurses' notes dated 7/10/12 through 7/12/12 at 6 a.m., disclosed no documented evidence that the hospice physician was made aware by the licensed staff of the resident's slightly cloudy, yellow urine with sediments since observed on 7/10/12. During an interview on 7/12/12 at 3:30 p.m., RN Supervisor 1 stated,"The resident's urine output was slightly cloudy and not reportable."	F 315	Cont'd. F 315 intervention. Treatment nurse will check all residents with indwelling urinary catheter daily, for the presence of leg strap to secure the catheter tubing and prevent dislodgement or trauma. * DON/ADON will check daily report book for any changes in residents' condition, new admissions, re-admissions, transferred and/or discharged residents, to allow DON/ADON to check/audit charts if appropriate interventions were done. Any discrepancies found will be corrected immediately, and will be discussed at the quarterly meeting of the QA Committee. * Corrective measures have been put in place and implemented by 7/16/12.	7/16/12
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328		

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F 328	Continued From page 13 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the physician's oxygen flow rate orders (Residents 1,16) and and failed to post a "No smoking/oxygen in use" as the facility policy indicated for a resident (Resident 17) for 3 of 5 residents who used oxygen in a sample of 20 residents. Findings: a. Resident 1 was admitted to the facility on 5/26/12, under the care of hospice due to diagnoses of failure to thrive and pain. According to admission face sheet, the resident had diagnoses of acute renal failure (rapid loss of kidney function), atrial fibrillation (irregular heart beat) and lump in the breast. On 5/30/12, the physician ordered checking of the resident's oxygen saturation every shift and to give oxygen through nasal cannula at a flow rate of two liters per minute if the oxygen saturation is below or equal to 90 percent. During the initial tour of the facility with Registered Nurse (RN) Supervisor 1 on 7/10/12 at 8:15 a.m., Resident 1 was observed asleep in bed with an ongoing oxygen inhalation through	F 328	F 328 * (a) On 7/11/12 MD clarified O2 therapy order for Resident 1 to O2 @ 2L/min via nasal cannula continuous for comfort/SOB. Check O2 sat Q shift. Notify VITAS hospice if O2 sat < 92%. DON provided one-on-one inservice to RN Supervisor & Charge Nurse of West Station 0n 7/13/12. (b) On 7/10/12 at 9:10 a.m., oxygen airflow for Resident 16 was re-adjusted to 2L/min. as originally ordered. DON provided one-on-one inservice to RN Supervisor & Charge Nurse of East Station on 7/13/12. (c) A "No Smoking/Oxygen In Use" sign was immediately posted on the door of Resident 17's room. DON provided one-on-one inservice to RN Supervisor & Charge Nurse of East Station on 7/13/12. DON provided one-on-one inservice to RN Supervisor &	

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F 328	Continued From page 14 nasal cannula at a flow rate of four and a half liters per minute. Further observations on 7/10/12 at 1:30 p.m., and at 4:15 p.m., revealed the resident's oxygen flow rate was observed still at four and a half liters per minute through nasal cannula. During an interview on 7/10/12 at 4:20 p.m., RN Supervisor 1 disclosed that licensed staff were responsible in monitoring the resident's oxygen flow rate. RN Supervisor 1 stated she did not check Resident 1's physician's order since the oxygen flow rate was observed at a rate of four and a half liters per minute at 8:15 a.m., on 7/10/12. On 7/10/12 at 4:25 p.m., the medication administration record (MAR) was reviewed with Licensed Vocational Nurse (LVN) 1. The MAR indicated that the resident's oxygen saturation level was 90 percent on 7/10/12, during the 7 a.m. to 3 p.m. shift. LVN 1 stated that the resident's oxygen saturation level was taken at 7:30 a.m., but she forgot to regulate the resident's oxygen flow rate to two liters per minute. b. On July 10, 2012 at 9:05 a.m. during initial tour and in the presence of licensed vocational nurse 2 (LVN 2) Resident 16 was observed lying in bed. The resident had on a nasal cannula (a device used to deliver supplemental oxygen or airflow to a patient or person in need of respiratory help) which was infusing at a rate of 3 liters (L) of oxygen per minute. Review of an "Admission Face Sheet", indicated Resident 16 was admitted to the facility on July 3,	F 328	Cont'd. F 328 Charge Nurse of West Station on 7/13/12; and to all nursing staff on 7/16/12 re: policy and procedure for oxygen administration, and emphasized to them the importance of making rounds and checking all residents on O2 therapy, to ensure they are getting the right amount of oxygen as ordered and "No Smoking/Oxygen in Use" signage in place. Prompt reporting to MD for any change in condition was also emphasized. CNAs were reminded that only licensed nurses are authorized to adjust and control the O2 tank/concentrator regulator. * All residents on O2 therapy were re-assessed and checked to ensure they are receiving the correct amount of oxygen and at the frequency as ordered. All residents with O2 orders were on the correct O2 flow rate. DSD made rounds to check if there is signage in rooms with	

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F 328	Continued From page 15 2012. The resident's diagnoses included atrial fibrillation and chronic obstructive pulmonary disease ([COPD] refers to a group of lung diseases that block airflow during exhalation making it increasingly difficult to breathe). A physician's order dated July 3, 2012, indicated oxygen was to be administered at a rate of 2 L per minute via nasal cannula continuously. Review of a care plan titled, "Respiratory Problem", dated July 3, 2012, indicated the resident was at risk for respiratory distress related to COPD and upper lobe lobectomy (a surgery in which a lobe of the lung is removed because there is a cancerous tumor in it). The care plan interventions included to administer oxygen as ordered. In an interview on July 10, 2012 at 9:10 a.m. LVN 2 was asked what the residents oxygen flow meter (devices that measure the amount of liquid, gas or vapor that passes through them) read. The nurse stated the resident's oxygen was infusing at a rate of 3 L per minute. Review of the facility's undated policy titled, "Policy on Oxygen Administration", indicated step one of the procedure for administering oxygen is to check the physician's order for liter flow and method of administration. The policy also indicated constant flow of oxygen can cause drying. c. On July 10, 2012, at 8:30 a.m., during a general observation, the evaluator observed Resident 17 lying in bed with an oxygen concentrator at the foot of the bed. Closer observation revealed that the oxygen concentrator was not in use. There was no "No Smoking/Oxygen in Use" sign posted outside of the room.	F 328	Cont'd. F 328 residents on O2 therapy. All signs were in place. * RN Supervisors and charge nurses will continue to perform regular visual rounds during their shift, to ensure that residents' condition are well monitored and proper intervention is done. Change of shift endorsement will be done between RN Supervisors/charge nurses of outgoing and incoming shifts. Emphasized to all licensed nursing staff the importance of following the order for oxygen saturation monitoring Q shift and PRN, as well as prompt reporting to MD of any change in condition for proper intervention. * DON/ADON will monitor that the corrective measures put in place is achieved and sustained by checking the daily report book to capture new orders for residents on O2 therapy. DON/ADON will make daily rounds to check that all	

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F 328	Continued From page 16 On July 10 2012 at 8:33 a.m., a review of Resident 17's medical record indicated that the resident was admitted to the facility on June 1, 2012, with diagnoses including dementia and shortness of breath (SOB). On June 1, 2012, the physician ordered that the resident receive oxygen at a rate of 2 liters per minutes via nasal cannula (a small tube to deliver oxygen to the nose), as needed for SOB. On the same day, a care plan was initiated for the concern of respiratory problem. The care plan approach indicated to administer oxygen as ordered. On July 10, 2012 at 9:10 a.m., the evaluator conducted an interview with the administrator regarding Resident 17's oxygen concentrator and that a "No Smoking/Oxygen in Use" sign was not posted outside of the resident's room. The administrator stated that she would have the nursing staff post a "No Smoking/Oxygen in Use" sign outside of the resident's room, immediately. On July 13, 2012 at 9:45 a.m., a review of the facility's (undated) oxygen administration policy and procedure indicated that the nursing staff are to place an "Oxygen in Use" sign per the facility policy.	F 328	Cont'd. F 328 residents with O2 therapy order are getting the correct amount of O2 level as ordered. This issue will be monitored and discussed at the quarterly meeting of the QA and Safety Committee. * The corrective measures/action were put in place and implemented by 7/16/12.	7/16/12
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	F 329 *(a) MD changed Resident 4's order of Restoril from 7.5 mg PO Q HS for insomnia to Restoril 7.5 mg PO Q HS PRN for insomnia. DON gave one-on-one in-service to 11-7 RN Supervisor on 7/13/12 who was assigned to tally hash marks (monthly) of all residents on psychoactive medication to promptly report	

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F 329	Continued From page 17 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 3 of 10 sample residents (4, 5 and 7) were free from unnecessary drugs. The facility staff failed to monitor the hours of sleep for Residents 4 and 5, while taking hypnotics (a drug or agent that induces sleep) and antidepressant medications on a daily basis. There was no documented evidence for the justification of continued use of these psychotherapeutic medications. Additionally, there was no documented evidence or indication to support an increase in the dosage of Desyrel (a type of medication used to treat depression) for Resident 7. These deficient practices had the potential to cause the deterioration of the residents physical,	F 329	Cont'd. F 329 or endorse to 7-3 RN Supervisor residents who have increased or decreased behavior so the 0psychiatrist and attending physician can be contacted for any changes in resident's behavior. (b) Resident 5 was on hospice care and expired on 7/11/12. In-service was given by DON on 7/16/12 to all licensed nurses on proper assessment, monitoring, observation and documentation of unnecessary use of medication especially antipsychotic, antidepressant, and antianxyiolytic and hypnotic medications, emphasizing the importance of re-assessment and offering nursing intervention first prior to giving any psychoactive medications. Prompt reporting to psychiatrist or attending physician any significant change in resident's behavior, proper documentation, revision and updating of care plans to	

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F 329	Continued From page 18 mental and psychosocial needs. Findings: a. Resident 4 was admitted to the facility on May 18, 2012, with diagnoses that included vertigo (a feeling of spinning movement), osteoporosis (thinning of the bones) and hypertension (high blood pressure). A review of the Minimum Data Set (MDS) dated May 28, 2012, indicated that Resident 4 had the ability understand others, usually was able to make self understood by others and required extensive assistance to totally dependent on staff for her activities of daily living (ADL's). The clinical record was reviewed with the director of nurses (DON) on July 10, 2012 at 10 a.m. There was a physician's order dated May 18, 2012, for Restoril 7.5 milligrams (mg) by mouth every night (qhs) for insomnia. The DON stated that the resident was already taking Restoril 7.5 mg during admission. The DON further stated that the facility just continued the medication as ordered by the physician. The DON also stated that there was no assessment done prior to the administration of Restoril. On June 10, 2012, at 10:15 a.m., a review of the care plan for insomnia dated May 18, 2012, did not include to monitor the resident's hours of sleep, so as to determine if the medication was effective. During an interview with the Licensed Vocational Nurse (LVN) 1 on July 10, 2012, at 11 a.m., she stated that the staff were only monitoring the	F 329	Cont'd. F 329 support the gradual reduction or discontinuation of any psychoactive medications. (c) Resident 7 had increasing episodes of undressing, agitation and climbing out of bed during 7-3 and 3-11 shifts, as evidenced by tally hash marks (Haldol) on monitor behavior for undressing, agitation and climbing out of bed, which caused insomnia. Desyrel was increased due to insomnia. Licensed nurses failed to record hash marks for dementia monitor behavior for insomnia. Effective 7/13/12 Licensed Nurses are accurately monitoring and recording the episodes of depression monitor behavior insomnia. In-service was given by DON on 7/16/12 to all licensed nurses on proper assessment, monitoring, observation and documentation of unnecessary	

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F 329	Continued From page 19 resident for episodes of insomnia and not the hours of sleep. The licensed nurse showed the Evaluator the Medication Administration Record (MAR) for the month of May 2012, where Resident 4 had a few episodes of insomnia. The months of June 2012, and July 2012, revealed the resident had zero (0) episodes of insomnia for the 3 p.m. to 11 p.m. shifts. On July 10, 2012, at 11:30 a.m., Resident 4 was observed sitting in a wheelchair in her room watching television. During an interview at the same time, Resident 4 stated that she did not have any problem falling asleep or staying asleep at night. The resident further stated "they gave me the pills every night, and I just take them." Although the resident had no episodes of insomnia recorded on the MAR for June or July 2012, there was no documented evidence that the facility attempted to reduce the use of the Restoril. b. A review of the admission record of Resident 5 on July 10, 2012, at 10:30 a.m., indicated the resident was originally admitted to the facility on May 5, 2009, and was re-admitted on April 5, 2012, with diagnoses of cancer of the esophagus (the tube that carries food, liquids and saliva from your mouth to the stomach), dysphagia (difficulty in swallowing), seizure disorder, diabetes mellitus (high sugar in the blood). A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated March 12, 2012, indicated the resident was independent with cognitive skills for daily decision making and required extensive	F 329	Cont'd. F 329 use of medication especially antipsychotic, antidepressant, and antianxyiolytic and hypnotic medications, emphasizing the importance of re-assessment and offering nursing intervention first prior to giving any psychoactive medications. Prompt reporting to psychiatrist or attending physician any significant change in resident's behavior, proper documentation, revision and updating of care plans to support the gradual reduction or discontinuation of any psychoactive medications. Emphasized to 3-11 & 11-7 shifts Licensed Nurses the importance of accurately recording and monitoring the episodes of dementia monitor behavior for insomnia. * DON will assess residents having potential to be affected by this deficient practice by involving pharmacy consultant to closely audit residents on pyshoactive medications on	

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F 329	Continued From page 20 assistance with his activities of daily living (ADL's). On April 5, 2012, the physician wrote an order to administer Desyrel 50 mg one tablet via gastrostomy tube every night for insomnia. A review of the care plan for insomnia dated April 5, 2012, did not indicate to monitor the resident's hours of sleep. The facility's psychotropic assessment dated April 5, 2012, indicated the team recommendation: monitor behavior as ordered. The resident's MAR for the months April 2012, May 2012, June, 2012, and July 2012, for insomnia record indicated that the resident had zero (0) events. During observation on July 10, 2012, at 2 p.m., Resident 5 was observed lying in bed. At 2:30 p.m., on the same day, during an interview with the licensed nurse, she stated that Resident 5 was always asleep most of the time. The licensed nurse also stated that the staff just followed the hospice care order for Desyrel that was to be given every night for sleep. The licensed nurse also stated that the resident was not assessed to determine why the resident was not able to sleep, prior to administering the sleep medication. During an interview with the DON on July 10, 2012 at 2:30 p.m., she stated the staff should have assessed the reason why the resident was not able to sleep, prior to administering the medication. c. Review of the "Admissions Face Sheet", indicated Resident 17 was admitted to the facility on June 1, 2012. The resident's diagnoses	F 329	Cont'd. F 329 regular basis, during her monthly review of residents' medications. Licensed nurses were provided in-service on proper assessment, monitoring, observation and documentation of unnecessary use of medication especially antipsychotic, antidepressant, and antianxyiolytic and hypnotic medications, emphasizing the importance of re-assessment and offering nursing intervention first prior to giving any psychoactive medications. Prompt reporting to psychiatrist or attending physician any significant change in resident's behavior, proper documentation, revision and updating of care plans to support the gradual or discontinuation of any psychoactive medications. * DON will randomly check MAR of those residents who are on psychoactive medications such as antipsychotics, antidepressants, antianxiolytics	

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F 329	Continued From page 21 included dementia (a group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning) and shortness of breath. Review of a Minimum Data Set (MDS), an assessment and care screening tool, dated June ~~11~~, 2012, indicated the resident was rarely understood and rarely able to understand others. According to the MDS the resident did not display any symptoms such as feeling or appearing down, depressed, or hopeless. Nor did the resident exhibit any signs of trouble falling asleep or sleeping too much. The resident was totally dependent on staff for transfers, dressing, eating, and personal hygiene. Review of a physician's order dated June 14, 2012, indicated discontinue Trazadone (an antidepressant used to treat depression and anxiety disorders) 50 milligram (mg) one tablet administered to the resident by mouth at bedtime. Start Trazadone 100 mg to be administered by mouth to the resident at bedtime. The indication for prescribing the medication was for depression manifested by insomnia. Review of the form"Psychotropic Summary Sheet" dated June 1 through June 14, 2012, indicated Trazadone 50 mg for insomnia. The form indicated the resident had no incidents of insomnia for the entire two week period throughout all three shifts (day, evening, and night). In addition the form indicated the Trazadone was increased from 50 mg to 100 mg on July 14, 2012. Review of another , "Psychotropic Summary Sheet", dated June 14 through June 30, 2012, indicated Trazadone 100	F 329	Cont'd. F 329 & hypnotic medication, etc., making sure that hash marks tally with the intervention provided by licensed nurses. DON will review the Policy & Procedure for psychoactive medication administration and monitoring of behavior with the licensed nurses during their monthly mandatory meeting. Will have close collaboration with pharmacy consultant and medical director in obtaining timely response from attending physicians of residents who are due for dose reduction or review, based on the pharmacy consultant's notes sent to them. * DON will monitor that corrective actions are achieved and sustained, and that deficient practice does not recur by reviewing the charts of all residents on antipsychotics, antidepressants, antianxiolytics and hypnotic medications. Follow-up with RN Supervisor in charge of monthly summary	

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F 329	Continued From page 22 mg for depression manifested by insomnia. The form indicated the resident had no incidents of insomnia for the entire two week period throughout all three shifts. Review of the, "Medication Administration Record (MAR)", dated July 2012, indicated the resident had no episodes of insomnia from July 1 through July 12, 2012 on neither the 3 p.m. to 11 p.m. shift nor the 11 p.m. to the 7 a.m. shift. (evening and night shifts). In an interview on July 13, 2012 at 8:05 a.m., registered nurse (RN) 2 was asked what the reason was for the increased dosage of the medication Trazadone. The RN stated she was unsure and was unable to find documentation indicating Resident 17 was exhibiting increased insomnia. According to the RN both Psychotropic Summary Sheets for the month of June 2012, indicated the resident was not having any insomnia. The RN stated the zeros on the summary sheets indicated the patient was able to sleep. In an interview on July 13, 2012 at 9:35 a.m., the director of nursing (DON) stated that according to the Psychotropic Summary Sheets for the month of June 2012, the resident was not having any insomnia. According to the DON, she was not sure of the reason why the medication was increased but thought it might possibly be due to resident exhibiting the behavior of trying to climb out of bed. The DON was asked if climbing out of bed was an indication for the medication Trazadone to be administered. The DON stated no, it was not.	F 329	Cont'd. F 329 of behavior episodes manifested by this group of residents. Reports on this issue will be discussed at the quarterly meeting of the QA Committee. * Corrective action has been put in place and implemented by 7/16/12. F 364 * Egg temperatures were monitored by the dietary supervisor at subsequent breakfast meals to assure food was at the proper temperature. * Of the 100 residents in the facility at the time of survey, there were 85 residents who were getting meal trays who had the potential of being affected	7/16/12

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F 329	Continued From page 23 Review of the undated policy titled,"Policy and Procedure on Psychoactive Drugs", indicated review of episodes and adverse effects will be conducted by licensed nurses as well as the interdisciplinary team (IDT). The number of episodes will be recorded each month. The medical doctor (MD) will be notified if behavior had decreased or increased so appropriate changes in dose of medication can be obtained for MD. This is a repeat deficiency from the last recertification survey on April 29, 2011.	F 329	Cont'd. F 364 by this deficient practice. Test tray audits of egg temperature are being performed by the dietary supervisor and dietitian. * To resolve the issue of cold eggs/food, dietary staff will pre-warm the plates/dishes by placing them in the oven before starting the tray line. Dietary staff working on the tray line were given in-service on 8/2/12	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide food that was at the proper temperature. Two of eleven residents, who attended the group interview stated the breakfast hot foods were served cold. Findings: On July 12, 2012 at 10:15 a.m., a group interview was conducted with eleven alert and oriented residents. During the interview, two of the eleven residents stated that the hot food was served	F 364	on the importance of accuracy in serving residents' food to eliminate the need for dietary supervisor and/or assistant to open the lids to check before sending the trays to the floor. This will minimize unnecessary opening of the lids and avoid the warm food to get cold fast. Licensed nurses will continue to check accuracy before the CNAs pass the trays to the residents. *The dietary supervisor will continue monitoring during the tray line and her kitchen rounds to assure the appropriate process	

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F 364	Continued From page 24 cold, especially at breakfast. On July 13, 2012 at 6:50 a.m., the evaluator requested a test tray from the dietary supervisor and food temperatures were taken. The hot foods that were on the steam table consisted of oatmeal (170 Fahrenheit [F]) and scrambled eggs (150 F). At 7:01 a.m., the breakfast tray line started. At 7:43 a.m., the last food cart left the kitchen, with the test tray. At 7:44 a.m., the food cart arrived at its final destination and the resident trays were passed out by the nursing staff. At 7:49 a.m., the last tray was passed out to the residents and food temperatures were taken on the test tray. The oatmeal was 141.1 F, and the scrambled eggs were 109.7. The scrambled eggs tasted lukewarm. (The evaluator observed that the plates were not preheated, or kept warm, during the tray line. As the food was served on the plates, these plates were placed in insulated bases and covered with insulated domes.) On July 13, 2012 at 8:01 a.m., the evaluator conducted a brief interview with one of the two residents who attended the group interview that stated the hot food was served cold. When asked if the hot food was still served cold, the resident said yes. On July 13, 2012 at 9:15 a.m., the evaluator conducted an interview with the dietary supervisor, regarding the results of the test tray. During this interview, the dietary supervisor was informed that the scrambled egg temperature had dropped significantly. The dietary supervisor stated she would speak with the facility's registered dietitian to resolve this problem, as soon as possible.	F 364	Cont'd. F 364 is carried through, and will continue to do test tray audits. Results of the audits will be reported to the QA Committee during its quarterly meetings for the next 3 quarters. * Corrective action will be put in place and implemented by August 5, 2012. F 371 * The burned out refrigerator light bulb was immediately replaced from existing supply. The hole on the door was repaired with an epoxy sealant from existing supply. New gasket was ordered from West Coast Gaskets on 7/13/12, and installed by the company on 7/18/12 (see attached Invoice). * There was no adverse effect on the health and welfare of the 100 residents in the facility at the time of survey. Food Service Supervisor in-serviced	8/5/12

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F 371 SS=D	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and protect food under sanitary conditions, regarding one of four refrigeration units in disrepair. Findings: On July 13, 2012 at 6:50 a.m., during the kitchen tour, the evaluator observed that there were four refrigeration units throughout this kitchen. During closer observation, the evaluator noticed that the Victory refrigerator had one interior light bulb that was burnt out, a torn gasket (A gasket is the rubber seal, on the interior of the refrigeration unit, which insulates and keeps the cool air inside the unit.), and one of the two doors had a 1-inch hole on the interior side of the door. This refrigerator's interior temperature was 44.0 degrees Fahrenheit. On July 13, 2012 at 9:15 a.m., the evaluator conducted an interview with the dietary supervisor. During this interview, this	F 371	Cont'd. F 371 all dietary staff on 7/30/12 re: monitoring of all appliances and equipment in the kitchen to ensure they are in good working condition, and to promptly report to maintenance staff any breakdowns or discrepancies for repairs. * The dietary staff assigned to do the weekly cleaning will also check all appliances and equipment to capture any breakdowns or repairs that need to be made, and promptly report it to the maintenance staff by recording it in a logbook provided in the dietary office. Maintenance staff will check the logbook daily to capture all work orders/repairs to be performed. Maintenance staff will also include checking of all equipment and appliances in the kitchen when they perform their monthly safety inspections. * The Food Service Supervisor and Administrator will monitor	

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F 371	Continued From page 26 refrigerator's defects were brought to her attention. The dietary supervisor stated these items would be corrected, as soon as possible.	F 371	Cont'd. F 371 that this deficient practice does not recur through weekly cleaning activities of dietary staff, and from monthly safety inspection reports from Maintenance staff. A report on this matter will be given at the quarterly meeting of the QA Committee. * This corrective measure was put in place and implemented by August 5, 2012.	8/5/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431	F 431 *The contracted pharmacy was immediately called to follow-up delivery of the replenished IV/IM E-kit. E-kit was delivered in the evening of 7/10/12. * All 100 residents in the facility at the time of survey had the potential of being affected by the deficient practice. DON checked all the E-kits (IM/PO/IV) to ensure there were no open E-kits that have	

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F 431	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to ensure that emergency (E-kit) medications were replenished by the pharmacy immediately after the E-kit was opened. This had the potential to result in the inability of the facility to provide IV/IM injections for the residents use in the event of an emergency. Findings: On June 10, 2012 at 10 a.m., during inspections of the West Nursing Station Medication Room with the Registered Nurse (RN) 2, revealed the intravenous/intramuscular (IV/IM) injection E Kits, had white cable ties. The RN 2 stated the white cable ties indicated the IV/IM E-kits had been opened and were awaiting to be replaced by the pharmacy supplier. When asked when the E-kit was last opened, the RN 2 stated she was not sure of the date it was opened. RN 2 further stated that she would find out from the nursing staff. On the same day at 10:15 a.m., RN 2 stated to the Evaluator, that the pharmacy log (a record of of all items used from the E-kit) was left inside the E-kit box so she was not able to determine when the E-kit was last opened. RN 2 further stated that she would look for extra white cable ties so she could open the E-kit. At 11:30 a.m., RN 2 showed the evaluator the "Pharmacy Log" that revealed IV/IM E-kit was opened on June 29, 2012, (11 days ago).	F 431	Cont'd. F 431 not been replenished, and will continue to do so with the help of the 7-3 RN Supervisors who will check the E-kits daily, and will give report to DON during daily meeting. Licensed Nurses were given in-service on 7/11/12 by DON regarding the revised policy and procedure for E-kit ordering and follow-up, emphasizing the importance of calling the pharmacy and also faxing the order as soon as he/she opens and uses the E-kit. * The policy and procedure for E-kit ordering and follow- up was revised, presented to, and approved by the QA Committee during its quarterly meeting on 7/11/12. Licensed Nurses were provided a logbook for documenting the following: name of nurse placing order, patient's name, item used from E-kit, dose, time given, and name of pharmacist taking the order. Licensed Nurses were	

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F 431	Continued From page 28 During an interview with the Director of Nursing (DON) on June 10, 2012 at 11:30 a.m., she acknowledged the facility's failure of not replenishing the emergency kit. The DON also stated that she would propose to the Committee that E-kits be replaced within 72 hours once it was opened. On June 11, 2012 at 2 p.m., the DON showed the facility's approved and signed by the Quality Assessment and Assurance Committee (QAA- refers to the planned and systematic activities implemented in a quality system so that quality requirements for a product or service will be fulfilled) new policy and procedures dated June 11, 2012, indicating that, "Once the licensed nurse opens and uses the E-kit, he/she needs to call the pharmacy and at the same time, fax the order. Everyday within 72 hours, licensed nurse will endorse and follow up with the pharmacy until E-kit is delivered to the facility."	F 431	Cont'd. F 431 instructed that everyday within 72 hrs. of placing the order, licensed nurses will endorse to each other, and follow-up with pharmacy until the E-kit is delivered to the facility. Licensed nurses were also instructed not to re-open or re-use E-kit after 72°. DON will be notified after 48° of ordering E-kit and not receiving the new one, to allow her to follow-up with pharmacy and ensure delivery is made within 72° as stipulated by the policy and procedure. * To ensure this deficient practice does not recur, all corrective actions are achieved and sustained, the DON will continue to monitor the licensed nurses to determine if they follow the provisions of the revised policy and procedure. Monitoring will be done thru' reports at the daily meetings by two (2) 7-3 shift Supervisors who are assigned to check the 2 med rooms daily for any open	
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	F 441		

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F 441	Continued From page 29 (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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an infection control program designated to provide a safe environment and to help prevent the development and transmission of disease, regarding physical examinations and tuberculosis (TB) screening for recently hired employees. One of six newly hired employees did not have a thorough physical examination and TB skin test in a timely manner, in accordance with the facility's policy. Findings:	F 441	Cont'd. F 431 E-kits. A report on this matter will be made at the quarterly meeting of the QA Committee for the next 3 quarters. * The corrective measures were put in place and implemented by 7/12/12. F 441 * DSD called the physician's office to verify/confirm the health clearance written on a prescription note provided to the housekeeping staff dated May 4, 2012. On 8/8/12 received a verification letter signed by the physician on their office letterhead * DSD checked files of other employees to ensure evidence of health examinations are in place, and have been performed or submitted within the 14-day period stipulated in our policy.	7/12/12

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F 441	Continued From page 30 On July 12, 2012 at 1:05 p.m., the review of six newly employed staff files were conducted. The six employees were hired between November 8, 2011 and May 30, 2012. One of the six employees (a housekeeping staff) was hired, on April 19, 2012. The housekeeping staff's employee file contained a (3-inch by 4-inch) physician's prescription note dated May 4, 2012, with a handwritten message that read, "Patient named above is healthy for work. TB is negative." The five other employee files had physical examination forms completed and signed by physicians. The five employee files also had documentation of either TB skin tests or chest x-rays, with the results for TB screening. On July 12, 2012 at 1:55 p.m., a review of the facility's policy and procedure for employee physical examinations indicated, "Pre-employment physical examinations and chest x-rays or TB skin tests are required of all new employees, no later than 14 days after the start of employment. TB skin tests may be obtained from the nursing office if desired. If you show a positive skin test, you will then be required to obtain a chest x-ray." On July 12, 2012 at 2:50 p.m., the evaluator conducted an interview with the Staff Developer (SD) regarding the housekeeping staff's physical examination and TB screening. During this interview, the evaluator mentioned that the housekeeping staff's employee file only had a physician's prescription note with the handwritten message. This note was dated 16 days after the employees hire date. The SD stated she would contact the housekeeping staff's physician to	F 441	Cont'd F 441 Health examinations for all other employees are in place and done timely. This deficient practice did not have an adverse effect on the health and welfare of the 100 residents who were in the facility at the time of survey. * DSD will ensure that all newly-hired employees will have health examinations done and submitted on a timely basis. The facility provides annual and upon employment health examinations to all employees. Arrangement has been made with our Medical Director who schedules monthly health examination at the facility, to have newly-hired employees examined at his nearby clinic if they are hired more than 14 days from the date of the scheduled monthly exam. Employees working in another facility and was provided a health examination there will be required to submit to us a copy of such examination within the 14-day period from start of	

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F 441	Continued From page 31 verify the results of the physical examination and the TB screening.	F 441	Cont'd F 441 employment. Newly-hired employees opting to have the health examination done by their physician will have to adhere to the same guidelines. Those who fail to provide such evidence timely will not be placed on the schedule until they submit the required paperwork. * Administrator will monitor that this deficient practice does not recur, and that corrective measures and systemic changes are effective and sustained, by conducting random checks of employee's files, particularly the newly-hired employees. DSD will make a report on this matter at the quarterly meeting of the QA Committee for the next 3 quarters. * The corrective measures were put in place and implemented by 8/5/12.	8/5/12
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for the residents and staff, regarding missing wall tile, missing wallpaper and an unsecured shower drain cover in one shower room. Findings: On July 12, 2012 between 8:25 a.m. and 11:15 a.m., the evaluator conducted a general observation of the facility and observed the following: a. At 9:15 a.m., one of two shower floor drain covers was unsecured, inside the shower room, next to Room 27. All of the floor drain covers in the shower rooms were 4-inches in diameter. b. At 9:28 a.m., a piece of wallpaper was missing on the corridor wall next to the handrail near Room 32. The missing wallpaper measured 3-inches by 3-inches. c. At 10:20 a.m., bathroom tiles were missing on the wall near the hand washing sink inside the	F 465		

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	056080	A. BUILDING _____ B. WING _____	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLINDA IMPERIAL CONV HOSP	150 BELLEFONTAINE PASADENA, CA 91105

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F 465	Continued From page 32 men's public restroom. The missing wall tile measured 2-inches by 8-inches. On July 13, 2012 at 10:30 a.m., the evaluator conducted an interview with the maintenance supervisor regarding the unsecured shower drain cover, the missing wallpaper and the missing bathroom tiles. During this interview, the maintenance supervisor stated he would secure the shower drain cover, provide wallpaper to the corridor wall, and provide wall tile at men's public restroom, as soon as possible.	F 465	F 465 * (a) Shower floor drain covers in shower room next to Room 27 were immediately secured. (b) The wall with the missing wallpaper will be repaired. (c) The missing tiles on the wall inside the men's public restroom were replaced from existing supply.	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to train the employees regarding emergency procedures. Three of six facility staff did not know the facility's emergency procedures during a power outage, which could possibly delay the staffs' response time. Findings: On July 10, 2012 at 8:15 a.m., the evaluator reviewed the facility's disaster manual. The manual indicated that the facility's emergency generator would provide electricity to the red electrical outlets (during power outages). The	F 518	* Maintenance staff made rounds of the physical plant to capture any other discrepancies that may have been missed. This deficiency affected the aesthetics of the facility but no adverse effect on the health and welfare of the 100 residents in the facility at the time of survey. * Maintenance staff will continue to make their regular/monthly rounds of the physical plant to capture any discrepancies that need to be attended to. Repairs/adjustments will be made immediately upon discovery of these	

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F 518	Continued From page 33 manual also indicated that the staff should plug the residents' medical equipment into the emergency extension cords (located in the disaster kits, at the nursing stations) and then plug the extension cords into the red electrical outlets. On July 12, 2012 at 10:10 a.m., a 7 a.m. to 3 p.m. shift Registered Nurse did not know about the emergency generator or that it would provide electricity to the red electrical outlets during power outages. On July 12, 2012 at 3:20 p.m., a 3 p.m. to 11 p.m. shift Certified Nursing Assistant did not know about the emergency generator or that it would provide electricity to the red electrical outlets during power outages. On July 13, 2012 at 8:05 a.m., a 7 a.m. to 3 p.m. Licensed Vocational Nurse did not know about the emergency generator or that it would provide electricity to the red electrical outlets during power outages. On July 13, 2012, at 8:50 a.m., the evaluator conducted an interview with the administrator regarding the emergency procedure staff interviews. During the interview, the administrator was informed that three of six staff did not know about the emergency generator or that the generator would provide electricity to the red electrical outlets during power outages. The administrator stated all the staff would be in-serviced on the facility's emergency procedures, as soon as possible.	F 518	Cont'd. F 465 discrepancies. The housekeeping staff have been instructed to report to maintenance staff via the logbook in each nursing stations, any discrepancies requiring attention that they noted in the course of performing their duties. Maintenance staff will continue to check the maintenance logbooks twice a day to capture any reports of discrepancies. Urgent matters will be brought to the attention of the maintenance staff immediately through verbal report. * The Administrator will monitor through monthly rounds reports from maintenance staff and other Department Heads who conduct regular rounds of the floor. Administrator will also conduct personal visual checks and observations randomly to ensure these deficiencies do not recur; or that	

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F 518		F 518	Cont'd. F 465 any discrepancies are attended to and resolved promptly. The Maintenance Supervisor will make his report at the quarterly meetings of the QA Committee. * All repairs and corrective actions will be completed by August 5, 2012.	8/5/12

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F 518		F 518	F 518 * One-on-one inservice was provided to the 3 staff members involved, focusing on the location of the emergency generator and the use of the red electrical outlets during power outages. * Inservices were provided to all employees on 7/16/12 re: emergency generator. No adverse effect on the health and welfare of the 100 residents in the facility at the time of survey. * Orientation of newly-hired employees include a tour of the facility (inside & outside), specifically showing them the different emergency equipment and shut-offs. The location of the emergency generator was added to the list of information located in the back of the employee's badge. Quarterly fire and disaster drills will continue to be conducted by an accredited consultant. DSD will conduct random checks by questioning employees about	

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F 518		F 518	Cont'd F 518 this matter, to determine their knowledge of it. In-service regarding the emergency generator and the use of the red outlets will be given at least twice a year during the monthly staff meetings. * Administrator will randomly check personnel files of newly-hired employees to ensure proper orientation has been given, and will review DSD's calendar of in-services to ensure the topic about emergency generator and red outlets are included. DSD will make a report on in-services provided, especially on this matter at the quarterly meetings of the QA Committee. * Corrective actions have been put in place and implemented by July 17, 2012	7/17/12