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

PRINTED: 12/01/2015
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
	056143	A. BUILDING _____ B. WING _____	11/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTINELA SKILLED NURSING & WELLNESS CENTRE EAST	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey and an Entity Reported Incident (ERI) investigation. ERI: CA00464202-Substantiated with no regulatory violation. No deficiencies were issued as a result of ERI #464202. Representing the Department of Public Health: 16282, RN HFEN 28187, RN HFEN Census: 52 Total Sample Size: 14 Highest severity and scope - E	F 000	**Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.** **F246** **Corrective action for residents found to have been affected by this deficiency:** Upon identification, Resident # 4 toilet seat was replaced according to his height and needs for safety and comfort. Resident # 9 was discharge AMA with the MD knowledge.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility staff failed to provide	F 246	**Corrective action for residents that maybe affected by this deficiency:** The Staff Developer and Charge nurses will be responsible for conducting daily rounds and ensuring that all residents using portable toilet seat as indicated was provided. An in-service was given by the Director of Staff	

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HFEN FACILITY INSPECTION BRANCH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/11/15

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

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F 246	Continued From page 1 reasonable accommodations of individual needs and preferences for two of 14 sample residents (4, 9). Resident 4 was not consistently provided a portable toilet seat to ensure safety and to prevent fall and Resident 9 was instructed to sign out against medical advice (AMA) for a trip to the department store for shopping. This deficient practice was a violation of the resident's rights and potential for injury and displacement. Findings: a. On November 15, 2015, at 8:30 a.m., during an interview Resident 4 complained of the toilet in his bathroom being to low for him to use safely. The resident further stated he has had falls and near falls due to having trouble trying to get off of the low toilet seat. The portable toilet seat,which is higher, not always available for his use and the staff only sometimes helps him to the toilet but does not return back to help him off the low toilet. A review of the Face sheet indicated Resident 4 was admitted to the facility on November 4, 2014, with diagnoses included encephalopathy (disease, damage, or malfunction of the brain manifested by an altered mental state that is sometimes accompanied by physical changes) and blindness in one eye. A review of the Minimum Data Set, a standardized assessment and care screening tool, dated November 4, 2015, indicated the resident had an intact cognitive skills for daily decision making. The resident was not steady, only able to stabilize with staff assistance moving on and off toilet, required extensive assistance with toilet use, personal hygiene, locomotion, and dressing. The resident was always continent of	F 246	Development and the Director of Nursing to all CNAs, licensed nurses and Social Service Personnel regarding the policy on Residents right-Accommodation of needs. The Director of Nursing provided a thorough in-service on 12/3/2015 regarding the policy on AMA to all licensed Nurses. **Measures that will be put into place to ensure that this deficiency does not recur:** The Director of Staff Development and charge nurses will make a daily and random rounds to ensure on all residents have a proper toilet seat as indicated. The Social Service will make daily rounds to ensure all residents request and needs addressed in timely manner. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Trends and concerns will be communicated to the quarterly QA steering committee by the Director of Nursing for further evaluation.	12/3/15

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F 246	Continued From page 2 bowel and bladder. A review of the Fall Risk Assessment dated November 4, 2015, indicated Resident 4 was at high risk for falls. A review of the resident care plan for the risk of fall and injury and decline in activity of daily living, indicated there was no documented evidence the resident's need for a higher toilet seat was addressed. On November 15, 2015, at 4:05 p.m., during an interview with a certified nursing assistant 2 (CNA 2) stated Resident 4 goes to the bathroom alone. CNA 2 stated one time the resident did ask for the high toilet chair/seat to use for the toilet. The high portable toilet seat is not always available because other residents uses it also. CNA 2 further stated she was aware the resident had problems getting on and off of the toilet because it was low. CNA 2 was helping the resident to the toilet only sometimes. b. A review of Resident 9's Face Sheet indicated the resident was admitted to the facility on October 29, 2015, with diagnosis that included syncope (temporary loss of consciousness caused by a fall in blood pressure). A review of the Admission Nursing Assessment dated October 29, 2015, indicated Resident 9 was oriented, agitated/anxious, paranoid, combative and able to propel a wheelchair. A review of the Daily Skilled Nursing Notes from November 1, through November 5, 2015, the resident was cooperative with care and treatment.	F 246		

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F 246	Continued From page 3 According to the Social Services Assessment dated November 2, 2015, the resident had no behaviors or psychosocial issues. On November 3, 2015, Resident 9 requested to go out to the department store to buy some items. Social services was to schedule transportation for the resident's request. A review of the Nurses Progress Notes dated November 5, 2015, at 9:50 a.m., indicated the resident verbalized he wanted to go out to the store today. The resident was told he needed someone to go with him and a staff from activities would take him the next day. The resident insisted on going on November 5, 2015 and not the next day. Resident 9 was told he had no physician's order to go out and told to sign AMA form. According to the Minimum Data Set, a standardized assessment and care screening form, dated November 5, 2015, indicated the resident had an intact cognitive skills for daily decision making and had no behavioral symptoms present. On November 14, 2015, at 6:30 p.m., during an interview the director of nursing (DON) stated Resident 9 wanted to go to the store every day. The resident could not be taken to the store daily. The risk and benefits of going out alone were explained and the resident signed out AMA.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	**F309** **Corrective action for residents found to have been affected by this deficiency:**	

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F 309	Continued From page 4 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the licensed nurses failed to evaluate effectiveness of the resident's dry skin treatment to provide the resident with a relief from itching and scratching and to consistently monitor the resident's apical pulse every shift as ordered for one out of 14 sample residents (2). This deficient practice placed the resident at risk for pain and discomfort and potential for skin injury and infection and placed the resident at risk of having apical pulse out of range not recognized which potentially could lead to cardiovascular complications. Finding: a1. On November 12, 2015, at 6:00 p.m., November 13, 2015, at 5:20 p.m., and on November 14, 2015, at 11:45 a.m. and 12:45 a.m., Resident 2 was observed scratching her severely dry, inflamed, flaky, pale colored skin on her arms, chest, head, scalp and other generalized body areas. During an interview on November 14, 2015, 12:45 p.m., the resident complained of itchy dry skin. The resident stated she had severely dry skin and the only thing she was getting for it was A& D ointment which was not providing good relief from itching. The resident further stated she also was	F 309	Upon identification, Resident 2 skin re-assessment by the Primary Physician with new orders and Dermatology consult done last December 3, 2015. Pain management and discomfort was addressed by the primary care physician last November 14, 2015. The Director of Staff Development gave a 1:1 in service to CNA 1 and 2 regarding application of A and D ointment as indicated . **Corrective action for residents that maybe affected by this deficiency:** The Director of Nursing, on December 3, 2015, reviewed all residents with skin problems, apical pulse monitoring and on A and D ointment and no similar findings noted. An in-service education on Pain Management/Documentation, medication and documentation of treatment administration and proper way to check the Apical Pulse was provided to the licensed nurses by the DON on 12/3/2015 **Measures that will be put into place to ensure that this deficiency does not recur:**	12/3/15 11/14/15 12/3/15 12/3/15

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F 309	Continued From page 5 getting a pain pill for the pain from the itching. A review of the Face Sheet indicated Resident 2 was re-admitted to the facility on January 23, 2015, with diagnoses that included hypertension (high blood pressure) and diabetes (high blood sugar). A review of the care plan for generalized body dry skin dated January 24, 2015, indicated for the licensed nurses to administer medication and treatment as ordered, provide good skin care and to monitor skin for signs of improvement and assess for pain. A review of the Change of Condition Notes for general body itching dated April 10, 2015, indicated the resident was noted to be scratching and complaining of itching. Amlactin lotion was ordered and carried out, the resident was to be monitored. A review of the Short Term Problems note for general body itching dated April 10, 2015, indicated on May 11, 2015, the Amlactin lotion was discontinued and on May 12, 2015, Tramadol was ordered for scratching the skin. A review of the Minimum Data Se, a standardized assessment and care screening tool, dated August 31, 2015, indicated the resident had the ability to understand and be understood by others, had an intact cognitive skills for daily decision making and required extensive	F 309	The DON and licensed nurses will conduct observation rounds and random resident interviews daily for any new or persistent skin condition needing prompt follow up with attending physician and care plan escalation. The DSD and Pharmacy Nurse Consultant will conduct random skills competency of licensed nurses on correctly taking apical pulse during med pass observation. Findings will be reported to the DON for follow up. An In-service on Skin Assessment, Pain Management and Documentation , Proper way of checking the Apical Pulse, Medication Administration Policy was given 12/3/2015 by the Director of Nursing to all Licensed nurses. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur** Trends observed will be reported to the quarterly QA Committee for review and recommendation	12/3/15

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F 309	Continued From page 6 assistance with personal hygiene and total dependence for bathing. A review of the physician orders dated November 14, 2015, indicated to administer Tramadol every eight hours as needed for pain. Also there was an order dated May 12, 2015, to apply A&D ointment (is a skin protectant, by moisturizing and sealing the skin) to generalized dry skin every day for maintenance. A review of the Pain Assessment Flowsheet, indicated the resident was receiving Tramadol on November 1,2,3,6,7,8,9,10,12,13, and 14, 2015 for generalized body pain. A review of the Medication Administration Record (MAR) there was a zero recorded for the number of complaints of pain from November 1st through 13th, 2015. According to the Treatment Record A&D ointment was applied to the resident's dry skin every day for maintenance since March 30, 2015. A review of the resident's clinical record, treatment record and MAR indicated there was no documented evidence the licensed nurses monitored the resident's skin condition as ordered and care planned to ensure the effectiveness of treatment. On November 15, 2015, at 3:30 p.m., a certified nursing assistant 1 (CNA1) stated she attends to Resident 2 complains of itching sometimes. CNA 1 confirmed the resident scratching all over her body. CNA 1 had reported to the treatment nurse. Same day at 3:50 p.m., during an interview the treatment nurse stated Resident 2 had an order for A&D ointment every day. The resident always	F 309		

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F 309	Continued From page 7 had dryness and maintenance treatment. The treatment nurse was unable to provide documentation of an assessment or description of the residents skin before or after the treatment. At 4:15 p.m., during an interview CNA 2 stated the resident was always scratching and asking for A&D ointment and asking CNA 2 to apply it for her. a2. There was a physician's order dated January 27, 2015, to monitor Resident 2's apical pulse every shift. A review of the Medication Administration Record (MAR) indicated for October 2015, there was no documented evidence the resident's apical pulse was checked on 3 p.m. to 11 p.m. shift from October 1 to October 8, 2015. A review of the MAR for November 2015, indicated there was no documented evidence the resident's apical pulse was checked on 11 p.m. to 7 a.m. shift from November 1st through the 14th, 2015. On November 15, 2015, at 6:00 a.m., during an interview the licensed vocational nurse 3 (LVN 3) stated she monitored Resident 2's pulse with a blood pressure machine or she would take the apical pulse at the residents wrist. LVN 3 was unable to provide documentation of consistent monitoring of the resident's apical pulse in October and November 2015. Same day at 3:40 p.m., LVN 2 stated he monitored the resident's apical pulse however was unable to provide documentation of the apical pulse monitoring for November 2015.	F 309		
F 322	483.25(g)(2) NG TREATMENT/SERVICES -	F 322	**F322** **Corrective action for residents found to have been affected by this deficiency:**	

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F 322 SS=D	Continued From page 8 RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the resident who had a gastrostomy tube [(GT) a feeding tube surgically inserted into the stomach] and was able to eat food by mouth would not receive a feeding formula during oral meal consumption and would not have a full stomach prior to meal time for one out of 14 sample residents (2). This deficient practice placed the resident at risk for aspiration pneumonia and for low self-esteem due to lack of independent oral (by mouth) eating. Finding:	F 322	Resident 2 was assessed by the RN on 11/14/2015, and no signs and symptoms of aspiration or any untoward effects from eating food by mouth while receiving feeding formula via GT noted. Resident 2 was also evaluated by the Speech therapist and Registered Dietician on 11/14/15 and diet was changed to Regular CCHO, NAS diet from mechanical soft NAS CCHO diet, which Resident 2 tolerates well. **Corrective action for residents that maybe affected by this deficiency:** On 12/4/2015, the Director of Nursing did a complete review of all residents on GTUBE feeding that may prefer oral gratification and or advance the diet as tolerated with the Speech Therapist evaluations and no similar findings noted. **Measures that will be put into place to ensure that this deficiency does not recur:** An in-service was given by the DON to the licensed nurses and Dietary Supervisor 12/3/2015 regarding the policy on Resident rights- accommodation of needs	11/14/15 11/14/15 12/4/15 12/3/15

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F 322	Continued From page 9 On November 12, 2015, at 6:00 p.m., and November 13, 2015, at 5:20 p.m., Resident 2 was observed in bed with meal tray in front of her on a bedside table. The resident was observed receiving Fibersource feeding formula through a GT at 55 cubic centimeters (cc) per hour. On both days the resident complained of being too full as she attempted to drink the beverage and eat a portion of the meal served. A review of the Face Sheet indicated Resident 2 was admitted to the facility on January 23, 2015, with diagnoses that included the GT and disphagia (difficulty or inability to swallow). There was an order dated January 23, 2015, for the GT feeding with Fibersource HN at 85 cc per hour over 12 hours. According to the Enteral Feeding Assessment dated January 29, 2015, the resident was tolerating the formula in addition to oral meal intake. On March 10, 2015, the resident continued on the GT feeding as previously ordered with minimal oral intake of a mechanical soft diet. There was a significant weight loss secondary to poor intake by mouth. The GT feeding was changed to 55 cc per hour for 22 hours. On March 12, 2015, the resident requested to see the registered dietician (RD), the resident indicated she was unhappy with the chopped food. (mechanical soft). The resident indicated she did not have a problem chewing or	F 322	and preferences as well as timely evaluation of residents who would benefit from eating orally if the enteral or gastric tube is no longer medically necessary. In addition, emphasis was given on turning off tube feeding while resident is taking food orally to minimize risk for aspiration. The IDT will review the medical necessity of continuous feeding via gastric tube for residents who are on oral diet at the same time during IDT Care Conference or as needed. The Department Managers and licensed nurses, during daily observation rounds will focus on compliance with turning off tube feeding while taking food orally to minimize risk for aspiration. Findings will be reported to the DON for follow-up. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Trends and concerns will be communicated to the quarterly QA steering committee by the Director	

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F 322	Continued From page 10 swallowing, she wanted to be on a regular diet. The RD suggested a speech therapy (ST) evaluation. The ST evaluations were conducted on March 13, 2015, through April 3, 2015, and the resident made good progress in all stated goals. The resident's diet was upgraded to a mechanical soft diet with thin liquids for oral gratification. A review of the Minimum Data Set, a standardized assessment and care screening tool, dated August 31, 2015, indicated the resident had the ability to understand and be understood by others and was dependent on GT for nutrition with no swallowing disorder. A review of the Enteral Feeding Assessment dated October 22, 2015, indicated the resident remained on the tube feeding at 55 cc per hour for 22 hours, with 225 cc of water every 8 hours. The resident also continued on a mechanical soft diet with variable oral intake. The patient's weight was stable. On November 3, 2015, the weight was unchanged, the tube feeding and oral diet continued with minimal percentage of oral intake. On November 14, 2015, at 12:30 p.m., Resident 2's lunch tray was observed at the bedside with 100% of the meal on it. Resident 2 stated she did not eat the food because she did not like the mechanical soft diet with the ground food. She further stated she only eats food that she likes, she had eaten fried chicken, pastrami, fish and other regular foods brought from the outside. The resident said she gets to full with the formula infusing all the time, she wished the feeding	F 322	of Nursing for further review and recommendations.	

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F 322	Continued From page 11 formula could be stopped. The resident stated she wants to eat regular food, she had spoken to the physician, dietician and the nurses requesting a regular diet however nothing had been done. On November 14, 2015, at 1:40 p.m., the physician, RD and speech therapist were consulted. At 4:45 p.m., during an interview the resident's primary care physician (PCP) stated the resident's GT feeding should have been stopped while the resident was eating her meals. The PCP further stated he was not aware the patient had made such a significant improvement.	F 322		
F 323 SS=D	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 ensure hot water temperatures from the sink in Room 17 did not exceed 120 degrees Fahrenheit, which had the potential to cause injury to three ambulatory residents in the room. Findings: During an interview with licensed vocational nurse	F 323	**F323** **Corrective action for residents found to have been affected by this deficiency:** The maintenance supervisor adjusted the water heater thermostat on 11/14/2015 and it reads 115 degrees Fahrenheit. **Corrective action for residents that maybe affected by this deficiency:** The maintenance supervisor checked all other water heaters and no similar deficiency were noted on 11/14/2015.	11/14/15 11/14/15

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	056143	A. BUILDING _____ B. WING _____	11/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTINELA SKILLED NURSING & WELLNESS CENTRE EAST	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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F 323	Continued From page 12 10 (LVN 10), he stated three of the four residents in Room 17 were ambulatory. LVN 10 stated one resident ambulated independently, one resident ambulated with a cane and one resident ambulated with supervision. During an observation on November 14, 2015 at 9:30 a.m., the temperature of the hot water from the sink in Room 17 was checked with a thermometer by the maintenance supervisor. The thermometer read 133.1 degrees Fahrenheit. During an interview with the maintenance supervisor, on November 14, 2015, at 9:31 a.m., after reading the thermometer to be 133.1 degrees Fahrenheit, he stated hot water temperatures should be between 105 and 120 degrees Fahrenheit. The facility policy and procedure titled "Hot Water Supply: Delivery to Residents " undated, indicated for hot water used by residents, there shall be temperature controls to automatically regulate the temperature between 105 and 120 degrees Fahrenheit.	F 323	**Measures that will be put into place to ensure that this deficiency does not recur:** The maintenance supervisor and his designees will monitor compliance though daily rounds. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Trends and concerns will be communicated to the quarterly QA steering committee by the maintenance supervisor and administrator for further review and recommendations.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that they were free of a medication error rate of greater	F 332	**F332** **Corrective action for residents found to have been affected by this deficiency:** Resident 2 was assessed by the RN on 11/15/15 and no untoward effects noted from receiving her medications via GT instead of orally.	11/15/15

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F 332	Continued From page 13 than five percent. A medication pass observation on November 15, 2015, revealed two medication errors in a sampled size of 27 opportunities for error resulting in a cumulative error rate of 7.4 percent for one of 14 sampled residents (2). This deficient practice placed residents for potential risk of adverse side effect from the medication due to not reviewing all physicians orders prior to medication administration. Findings: On November 15, 2015, at 4:30 p.m., during the medication pass the licensed vocational nurse 1 (LVN 1) was observed crushing one tablet of Docusate Sodium (stool softener) and one tablet of Cranberry for administration to Resident 2. LVN 1 was observed mixing crushed medications with water and administering them through the resident's gastrostomy tube [(GT) a feeding tube surgically inserted into the stomach]. According to the Face Sheet Resident 2 was re-admitted to the facility on January 23, 2015, with diagnoses that included GT and disphagia (difficulty or inability to swallow). A review of the Minimum Data Set, a standardized assessment and care screening tool dated August 31, 2015, indicated the resident had the ability to understand and be understood by others and was dependent on the GT for nutrition with no swallowing disorder. A review of the physician order dated November 14, 2015, indicated to administer all medications	F 332	LVN 1 was provided 1:1 in-service regarding the Policy and Procedure of Medication Administration on 12/3/2015 by the Director of Nursing with focus on following physician's order, including the correct route of medication. **Corrective action for residents that maybe affected by this deficiency:** The DON and RN supervisor observed all licensed during medication administration on 11/15/15 and no similar findings noted. In-service given by DON to all licensed nurses on 12/3/2015 regarding correct route of medication administration as ordered and timely documentation of any new orders on the 24-hour communication log. **Measures that will be put into place to ensure that this deficiency does not recur:** The DON will validate skills competency of licensed nurses on medication administration, with emphasis on correct route, once a week X 4 and pharmacy consultant	12/3/15 11/15/15 12/3/15

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F 332	Continued From page 14 orally (by mouth) if tolerated by the patient. On November 15, 2015, at 4:40 p.m., during an interview LVN 1 stated he was not aware that Resident 2 was to get her medications orally. The day shift nurse was to endorse any changes to him and document in the 24-Hour Report of Resident's Change of Condition log. Upon review of the log, the change was not noted. The order for the medication to be administered orally was noted on the Medication Administration Record.	F 332	nurse will observe medication pass monthly. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Trends and concerns will be communicated to the quarterly QA steering committee by the Director of Nursing for further review and recommendations.	
F 457 SS=B	483.70(d)(1)(i) BEDROOMS ACCOMMODATE NO MORE THAN 4 RESIDENTS Bedrooms must accommodate no more than four residents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure two multiple resident bedrooms had no more than four residents in each room. Rooms 3 and 18 had 5 residents in each room. This deficient practice had the potential to result in not enough space for equipment and residents care. Findings: On November 12, 2015, at 5:40 p.m., during the facility's room-to-room initial tour, Rooms 3 and 18 were observed to have five residents in each room. A review of the Client Accommodations Analysis, dated November 12, 2015, indicated Rooms 3	F 457	**F457** **Corrective action for residents found to have been affected by this deficiency:** Rooms 3 and 18 have adequate furniture as well as spacing for all residents. The request letter for the waiver/variance to section 483.70 has also been submitted on 11/12/2015. **Corrective action for residents that maybe affected by this deficiency:** No other rooms contain more than 4 beds in the facility.	11/12/15

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F 457	Continued From page 15 and 18 housed five residents in each room. According to the document, Room 3 measured 422 square feet, and Room 18 measured 428 square feet. During an interview with the administrator, on November 15, 2015, at 4:15 p.m., he stated one resident was newly admitted to Room 3 on October 22, 2015. The administrator also stated one resident was newly admitted to Room 18 on October 23, 2015. During a review of a letter addressed to the administrator from Centers for Medicare & Medicaid Services (CMS), dated January 8, 2015, indicated the facility was granted a waiver/variation of the room size requirements. Observations from November 12, 2015, through November 15, 2015, of the care being provided to the residents by the staff in Rooms 3 and 18, indicated there was no negative effect to the residents related to the adequacy of space for nursing care and privacy.	F 457	**Measures that will be put into place to ensure that this deficiency does not recur:** The Director of Nursing, Director of Staff Development, Administrator, and their designees will conduct daily inspection to ensure that residents are safe and comfortable. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Trends and concerns will be communicated to the quarterly QA steering committee by the Director of Nursing, Director of Staff Development and Administrator for further review and recommendations.	