POC received & accepted by # 27680 12/29/15

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

PRINTED: 12/10/2015
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
	05A137	A. BUILDING _____ B. WING _____	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL PARK BEHAVIORAL HEALTH CENTER	1425 LAUREL AVENUE POMONA, CA 91767

DHCS APPEALS OFFICE HEALTH FACILITY EVALUATION DIVISION 2015 DEC 18 PM 1:35

(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	F 000		

The following reflects the findings of the Department of Public Health during an annual Recertification Survey and an Abbreviated entity reported incidents (ERIs) investigation.

Representing the Department:

11679, HFEN

36503, HFEN
36526, HFEN
07589, REH 1
35385, HFEN
27680, HFEN
36331, HFEN
36231, HFEN
35893, HFEN
36329, HFEN
36205, HFEN
36459, HFEN
36417, HFEN
Census:43
Sample Size: 11

S/S: E

CA00447765 substantiated with no regulatory violation
CA00450220 substantiated with no regulatory violation
CA00453325 substantiated with no regulatory violation
CA00454722 substantiated with no regulatory violation
CA00454726 substantiated with no regulatory violation

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Laurel Park Behavior Health Center does not admit that the deficiency listed on this form exist, nor does Laurel Park Behavior Health Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. Laurel Park Behavior Health Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

Silvia Rodriguez

F 325 SS E 483.25 (i)	pages: 04-11	**F 325; SS=E; 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **The following was completed as corrective action for those residents found to have been affected by the alleged practice. On 11/23/15, Resident 1's meal tray card changed to Consistent Carbohydrate Diet (CCHO) by Food Service Supervisor to reflect dietary physician's order. On 11/24/15, the Registered Dietitian re-assessed Resident 7 to ensure nutritional care and services are consistent with the Resident's comprehensive assessment and appropriate interventions were identified and initiated.**	**E. Dates when corrective action will be completed:**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Silvia Rodriguez, Silvia Rodriguez	Administrator	12-18-15

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 000	Continued From page 1 CA00455474 substantiated with no regulatory violation CA00455492 substantiated with no regulatory violation CA00455509 substantiated with no regulatory violation CA00457268 substantiated with no regulatory violation CA00457280 substantiated with no regulatory violation CA00458885 substantiated with no regulatory violation CA00459753 substantiated with no regulatory violation CA00460276 substantiated with no regulatory violation CA00461860 substantiated with no regulatory violation ~~CA00461962 substantiated with no regulatory~~ violation CA00462118 substantiated with no regulatory violation CA00462122 substantiated with no regulatory violation CA00462125 substantiated with no regulatory violation CA00462330 substantiated with no regulatory violation CA00462888 substantiated with no regulatory violation CA00464459 substantiated with no regulatory violation CA00464778 substantiated with no regulatory violation CA00464784 substantiated with no regulatory violation CA00465619 substantiated with no regulatory violation CA00407665 substantiated with no regulatory	F 000	**On 11/25/15, the Registered Dietitian re-assessed Resident 10 to ensure nutritional care and services are consistent with the Resident's comprehensive assessment and appropriate interventions were identified and initiated. Each resident's plan of care was reviewed and updated based on the assessment.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following was completed. On 11/23/15, Administrator and Food Services supervisor conducted an audit of meal trays for Residents identified with a CCHO diet ensure meal tray cards reflect dietary physician's order – no other issues identified. On 11/25/15, Residents who were identified for nutritional needs per their most recent Nutrition Assessment/Weight were reviewed by the Registered Dietitian and Director of Nursing Services to ensure nutritional care and services were consistent with the Resident's comprehensive assessment – no issues identified. On 11/23/15, the Food Service Supervisor conducted a visual audit of 10 tray passes to ensure meal accuracy – no other issues identified.** **C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:** **On 11/25/15, Registered Dietician and Director of Nursing Services were re-educated by the Administrator regarding**	

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F 000	Continued From page 2 violation CA00407672 substantiated with no regulatory violation CA00407673 substantiated with no regulatory violation CA00407674 substantiated with no regulatory violation CA00407675 substantiated with no regulatory violation CA00407676 substantiated with no regulatory violation CA00407678 substantiated with no regulatory violation CA00407681 substantiated with no regulatory violation CA00407682 substantiated with no regulatory violation CA00407683 substantiated with no regulatory violation CA00407685 substantiated with no regulatory violation CA00408221 substantiated with no regulatory violation ~~CA00407222 substantiated with no regulatory~~ violation CA00408223 substantiated with no regulatory violation CA00408224 substantiated with no regulatory violation CA00408225 substantiated with no regulatory violation CA00408226 substantiated with no regulatory violation CA00408227 substantiated with no regulatory violation CA00408228 substantiated with no regulatory violation CA00408229 substantiated with no regulatory violation	F 000	**Nutritional Care Process, including but not limited to ensure nutritional care and services are consistent with the Resident's comprehensive assessment. On 11/25/15, Administrator coordinated and completed an in-service with Food Service Supervisor regarding Diet Orders, including but not limited to ensuring meal tray cards reflect current physician orders. On 11/23/15 and until 12/14/15, Director of Staff Development coordinated and completed an in-service with licensed nursing personnel and Food Service Supervisor regarding Communication between disciplines, including but not limited assure timely communication related to nutritional care. On12/01/15 and until 12/14/15, Director of Staff Development coordinated and completed an in-service with licensed and certified nursing personnel regarding Early Warning Tool "Stop and Watch", including but not limited to certified nursing personnel identifying and communicating to licensed personnel when Residents are observed with patterns of refusing meals. On 11/25/15, Registered Dietitian coordinated and completed an in-service with dietary personnel regarding modified portion sizes, including but not limited to ensuring Residents are served accurately.** **D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:**	

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F 000	Continued From page 3 CA00408230 substantiated with no regulatory violation CA00408231 substantiated with no regulatory violation CA00408355 substantiated with no regulatory violation CA00408357 substantiated with no regulatory violation CA00408358 substantiated with no regulatory violation CA00408359 substantiated with no regulatory violation CA00408360 substantiated with no regulatory violation CA00408361 substantiated with no regulatory violation CA00408362 substantiated with no regulatory violation CA00408363 substantiated with no regulatory violation CA00408364 substantiated with no regulatory violation CA00423599 substantiated with no regulatory violation & CA00445502, CA00446475. CA00423733 substantiated with no regulatory violation CA408222, 408357, 461962, 464778	F 000	**Starting 11/23/15, Food Service Supervisor will complete audit of 20 Residents meal tray cards to assure meal tray cards reflect most current dietary physician orders weekly x4 then monthly for the next 2 months. Any findings will be corrected and re-education provided as indicated. Audits will be documented and reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action. Starting 11/25/15, Registered Dietitian and/or designee will complete audit of 5 Residents who are identified for nutritional needs per their most recent Nutrition Assessment/ Weight to ensure nutritional care and services are consistent with the Resident's comprehensive assessment weekly x4 then monthly for the next 2 months until substantial compliance achieved. Any findings will be corrected and re-education provided as indicated. Audits will be documented and reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action. Starting 11/23/15, Director of Nursing Services and/ or designee will complete an audit of 20 Residents Activities of Daily living form to identify patterns of refusing meals weekly x4 then monthly for the next 2 months. Any findings will be corrected and re-education provided as indicated. Audits will be documented and reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action. Starting 11/23/15, Food Service Supervisor will complete visual audits of 10 tray passes to ensure meal accuracy weekly x4 then monthly for the next 2 months. Any findings will be corrected and re-education provided as indicated. Audits will be documented and**	
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 4	F 325		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure three of 11 sampled residents (Residents 10, 1 and 7) were provided the nutritional care and services consistent with the resident's comprehensive assessment. This deficient practice has the potential for the residents' nutritional needs will not be met.

Findings:

A review of Resident 10's clinical record indicated, Resident 10 was admitted to the facility on 6/23/14, with the diagnoses that included the following: schizophrenia (a brain disorder in which people interpret reality abnormally), alcohol abuse, stimulant abuse (drugs that induce alertness, elevated mood), vitamin D deficiency, and antisocial personality disorder (a mental disorder characterized by disregard for other people).

A review of the Minimum Data Set (MDS), an assessment and care screening tool dated 10/7/15, indicated Resident 10 had clear speech, independent in activity and no difficulty in swallowing. Resident 10's initial weight was 172 pounds 9(lbs) since admission on 6/23/14.

During a review of the physician's order 8/26/15, indicated for the resident to receive Regular/Liberalized diet which was defined in the order as large portions for all meals.

reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action.

Monitored By:
Registered Dietitian, Director of Nursing Services, Director of Staff Development, Food Service Supervisor

Date of Completion:
12/18/15 — **12/18/15**

F 329 — **SS=E** — **483.25 (l)** — **pages: 11-17**

F 329; SS=E; 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:
On 12/18/15 the Director of Nursing Services coordinated the completion of re-review of Resident 1 and Resident 7's physician's orders and amended physician's order per attending Psychiatrist to reflect Residents specific target behavior symptoms. On 12/18/15, the Director of Nursing Services coordinated and completed documentation within the medical record to indicate what specific medication is being used to treat what specific behavior symptom.

B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:
In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed. By 12/25/15, the Health

E. Dates when corrective action will be completed:

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F 325	Continued From page 5	F 325		

During an observation on 11/25/15, at 7:50 a.m., in the dining hall, Resident 10 was observed eating a Danish (bread), scrambled egg, ½ a cup of cream of wheat and a cup of coffee.

During an interview with the food services supervisor on 11/25/15, at 9:40a.m., when asked if the resident was receiving large portion meals he stated no double portions are available for residents.

A review of resident's documented weights from 6/23/14 - 11/4/15, Resident 10 was noted to loss weight gradually as follows:
6/23/14= 172 lbs on admission.
10/10/14 = 165 lbs.
11/6/14 = 161 lbs.
12/3/14= 162 lbs.
4/2/15 = 160 lbs.
5/5/15= 158 lbs.
8/5/15 = 155 lbs.
9/2/15= 151 lbs.
11/4/15 =150 lbs.

The careplan was updated on 10/8/15, identifying the resident's weight loss, 3 months after admission. The intervention included: large portion of all meals and to encourage diet compliance and intake of 75%-100% of all meals.

A review of the activities of daily living (ADL) record, indicated during the month of October, the resident had 50% intake for breakfast on 10/14, 10/18, 10/19, 10/20 and 10/27. On 10/25 the resident had 25% intake for breakfast and lunch. On 11/10, 11/15, and 11/18, Resident 10 had 50% intake for breakfast. Resident 10 was not interviewed due to not being able to

Information manager will complete an audit for any Residents with psychoactive medication to ensure specific target behavior symptoms is indicated within the physician order – any findings immediately will be correct. By 12/25/15, the Health Information manager will complete an audit for any Residents with psychoactive medication to ensure to ensure Residents specific medication is being used to treat a specific target behavior symptom is indicated within the medical record – any findings immediately correct.

C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:

On 12/18/15, Director of Nursing Services coordinated and completed an in-service with licensed nursing personnel regarding Behaviors: Management of Challenging, including but not limited to documenting that a specific medication is being used to treat a specific target behavior symptom within the physician's orders and medical record.

D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:

Starting 12/21/15, the Health Information Manager will complete audits of 5 Residents medical records to ensure physician's orders and medical records indicate a specific

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F 325	Continued From page 6 cooperate. During an interview with the senior dietician on 11/15/15, at 11:40 a.m., who confirmed the resident's gradual weight loss stated that large portion refers to 1 and ½ cup more for food items. She also stated that sometimes french toast was added for breakfast but depends on what meal was being served for the day. b. A review of the Admission Record of Resident 1 indicated the resident was admitted to the facility on November 17, 2014, with diagnoses that included schizophrenia (a brain disorder in which people interpret reality abnormally), hypertension (high blood pressure), and morbid obesity (a body weight 100 pounds or more than what is medically recommended). A review of a physician's order dated August 11, 2015, indicated to provide the resident with a consistent carbohydrate diet (CCHO - a diet in which the resident receives roughly the same number of carbohydrates from meal to meal and day to day to help control blood sugar and/or weight) and give skim milk at breakfast and dinner. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated September 2, 2015, indicated the resident was able to complete the brief mental status interview, understands others and able to make self understood, and was independent in performing activities of daily living (ADL). The MDS indicated the resident weighed 232 pounds (lbs.) and had no five percent weight loss or weight gain in the last month or ten percent weight loss or weight	F 325	**medication is being used to treat a specific target behavior symptom x4 then monthly for the next 2 months until substantial compliance achieved. Any findings will be corrected and re-education provided as indicated. Audits will be documented and reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action.** **Monitored By:** **Director of Nursing Services, Health Information Manager** **Date of Completion:** **12/25/15** **F 431; SS=D; 483.60 (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** **A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:** **The following was completed as corrective action for the identified alleged practice. On 11/24/15, The Director of Nursing placed expired/ discontinued medications in a designated, secure location marked solely for expired and discontinued medications.** **B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:** **In order to identify other residents having**	**12/25/15** **E. Dates when corrective action will be completed:**
F 431 SS=D 483.60 (b), (d), (e) pages: 17-19				

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F 325	Continued From page 7	F 325		

gain in the last six months.

According to the Dietary Progress Notes dated November 13, 2015, the resident gained 29 lbs in the last six months weighing 236 lbs, resulting in a significant weight gain of 14%. The facility's registered dietician (RD) indicated to continue CCHO diet for weight management, encourage the resident to do physical exercise on a daily basis and make healthy choices during canteen, and avoid further significant weight gain per month.

A review of a plan of care dated November 16, 2015, indicated the resident has a nutritional problem manifested by resident having current or recent history of weight gain secondary to decreased activities and refusing therapeutic diet. The care plan further indicated the resident weighed 236 lbs with an ideal body weight of 180 to 182 lbs. The care plan goal indicated the resident will not have significant, undesirable weight gains and/or dehydration. The nursing interventions included for dietary staff to provide diet and nourishments as ordered by the physician and for dietary and nursing staff to monitor the resident's eating habits and adjust for food preferences as needed, offer healthy choices during canteen, and have the resident join morning exercise on the premise.

During a dining observation on November 23, 2015, at 12:40 p.m., Resident 1 was observed eating her lunch meal consisting of a fish fillet sandwich, potatoes, a bowl of soup, grapes, water and ice tea. The resident ate 100% of her meal.

During an interview on November 23, 2015, at

the potential to be affected by the same alleged deficient practice, the following was completed. On 11/25/15, The Director of Nursing completed an audit of expired/ discontinued medication to ensure expired and discontinued medications were stored in the designated, secure location marked solely for expired and discontinued medications – no issues identified.

C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:

On 11/23/15 and until 12/14/15, Staff Development Coordinator coordinated and completed an in-service with licensed nursing personnel regarding disposal/destruction of expired or discontinued medications, including but not limited to storing expired and discontinued medications in the designated, secure location marked solely for expired and discontinued medications.

D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:

Starting 11/25/15, Director of Nursing will complete audits of 20% of Resident medications to ensure expired/discontinued medications are stored in the designated, secure location marked solely for expired/discontinued medications weekly x4 then monthly for the next 2 months until

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12:40 p.m., the RD stated the resident is on a regular/liberalized diet based on what is indicated on her tray card.

On November 23, 2015, at 2:20 p.m., during another interview, the RD stated the resident should be on CCHO diet per physician's order, not regular/liberalized diet, to help control weight gain. According to the RD, they have already identified the problem and are making the necessary corrections.

c. A review of the Admission Record or Resident 7 indicated the resident was admitted to the facility on March 25, 2015, with diagnoses that included schizophrenia and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone).

A review of a plan of care dated July 21, 2015, indicated the resident has a nutritional problem manifested by the resident having current or recent history of weight loss trend secondary to pacing most of the time. The care plan further indicated the resident weighed 192 lbs on July 1, 2015 and has an ideal body weight of 144 to 176 lbs. The care plan goal indicated the resident will not have significant, undesirable weight losses and/or dehydration. The nursing interventions included for dietary staff to provide diet and nourishments as ordered by the physician, dietary and nursing staff to monitor the resident's eating habits and adjust for food preferences as needed, and nursing staff to monitor food intake/consumption daily.

A review of a physician's order dated October 8, 2015, indicated to provide the resident with a regular/liberalized diet and with large portions at

substantial compliance achieved. Any findings will be corrected and re-education provided as indicated. Audits will be documented and reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action.

Monitored By:
Director of Nursing Services

Date of Completion:
12/18/15 **12/18/15**

F 441	**F 441; SS=D; 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS**	**E. Dates when corrective action will be completed:**
SS=D	**A. What and how corrective action(s) will be accomplished, both temporarily and permanently, for those patients, employees, and/or facility operations identified/found to have been affected by the deficient practice:**	
483.65	**The following was completed as corrective action for the identified alleged practice. On 11/23/15, Licensed Vocational Nurse removed blood pressure cuff from the cabinet and disinfected blood pressure cuff prior to next usage. On 12/11/15, the four identified Residents were assessed by the Director of Nursing – no issues identified.**	
pages: 19-21	**B. How the facility will identify other patients, employees, and/or facility operations having the potential to be affected by the same deficient practice and what corrective action(s), both temporarily and permanently, will be taken:**	
	In order to identify other residents having the potential to be affected by the same	

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dinner.

The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated October 8, 2015, indicated the resident was able to complete the brief mental status interview, understands others and able to make self understood, and was independent in performing activities of daily living (ADL). The MDS indicated the resident weighed 182 pounds (lbs.) and had no five percent weight loss or weight gain in the last month or ten percent weight loss or weight gain in the last six months.

According to the Dietary Progress Notes dated November 4, 2015, the resident lost 25 lbs in the last six months weighing 175 lbs, resulting in a significant weight loss of 12.5% secondary to walking throughout the day. The facility's registered dietician (RD) indicated the resident continues on large portions at dinner and eats 100% of his breakfast and dinner meal and 50-100% of his lunch meal. The RD indicated to give the resident a bedtime snack of half a sandwich and 8 ounces of milk secondary to weight loss and per resident's request and to do weekly weights for four weeks and follow-up.

A review of the ADL record for November 2015, indicated the resident had refused his breakfast meal for three days, from November 21, 2015 to November 23, 2015. However, a review of the clinical record did not contain documentation that a licensed staff was aware of the resident's meal refusal, the resident was assessed for reasons for refusing his breakfast, and that the physician and/or the registered dietician was notified of the resident's breakfast refusal for three consecutive days.

alleged deficient practice, the following was completed. On 11/23/15, The Director of Staff Development completed a visual audit of blood pressure checks and verified licensed and certified nursing personnel disinfected blood pressure cup in between patient use – no issues identified.

C. What immediate measures will be put into place and/or what systematic changes the facility will make to ensure the deficient practice does not recur:

On 11/23/15 and until 12/14/15, Staff Development Coordinator coordinated and completed an in-service with licensed and certified nursing personnel regarding cleaning and disinfecting, including but not limited to disinfecting blood pressure cuff in between patient use.

D. How the facility plans to monitor its performance to make sure that solutions are sustained (description of the monitoring process and positions responsible for monitoring). The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:

Starting on 11/23/15, Staff Development Coordinator will complete visual audits of 10 blood pressure checks to ensure licensed and certified nursing personnel are disinfecting blood pressure cuff in between patient use weekly x4 then monthly for the next 2 months until substantial compliance achieved. Audits will be documented and reviewed at the monthly clinical excellence committee meeting x 3 months for further review of corrective action.

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F 325	Continued From page 10 During an interview on November 27, 2015, at 7:40 a.m., Licensed Vocational Nurse (LVN) 1 stated that the certified nursing assistant (CNA) did not inform him that Resident 7 has refused his breakfast meal for the past three days. During an interview on November 27, 2015, at 7:40 a.m., the RD stated that the facility staff just informed her that morning that the resident had refused breakfast for the past three days. According to the RD, she will assess and talk to the resident. On November 27, 2015, at 8:41 a.m., during an interview, Resident 7 stated that he would refuse breakfast at times because he is not hungry and usually gets hungry around lunch time. The resident stated that he likes his weight loss trend and prefers to weigh around 160 lbs, which is his usual body weight.	F 325	**Monitored By:** **Staff Development Coordinator** **Date of Completion:** **12/18/15**	**12/18/15**
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 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	F 329		
F 458 **SS=B** **483.70 (d)(1)(ii)** **pages: 21-23**		**F 458; SS=B; 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT** **Please see attached waiver.**	**E. Dates when corrective action will be completed:** **11/24/15**	

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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 two of 11 residents (1 and 7) on psychoactive drugs were free from unnecessary drugs in a total sample of 11 residents. This failures had the potential for the residents to receive unnecessary medications and to have possible side effects resulting from the medications.

For Resident 1, there was no specific target behavior symptom indicated on the physician's order and monitored for the use of the Geodon (antipsychotic), Haloperidol (antipsychotic), and Topiramate (anticonvulsant, can also be used as a mood stabilizer).

For Resident 7, there was no specific target behavior symptom indicated on the physician's order and monitored for the use of Abilify (antipsychotic), Depakote (mood stabilizer), Hydroxyzine (antihistamine), and Zyprexa (antipsychotic).

Findings:

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a. A review of the Admission Record of Resident 1 indicated the resident was admitted to the facility on November 17, 2014, with diagnoses that included schizophrenia (a brain disorder in which people interpret reality abnormally), hypertension (high blood pressure), and morbid obesity (a body weight 100 pounds or more than what is medically recommended).

A review of a care plan dated August 16, 2015, indicated the resident is on psychotropic drugs secondary to behavior/emotional problems manifested by resident having physician ordered psychotropic medications: antipsychotic and mood stabilizer secondary to resident manifesting behavior/emotional problems that have the potential to affect self, others, and environment secondary to issues with mood pattern, behavior pattern, and psychosocial well-being. The care plan goal indicated the resident will be free of medication related extra pyramidal reaction and/or falls and increase functional status via the interdisciplinary behavioral plans. The nursing interventions included to give routine and as needed (PRN) medications as ordered by the physician and to monitor laboratory, dietary compliance, environment, and/or medications for possible side effects PRN and report abnormals to physician promptly.

The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated September 2, 2015, indicated the resident was able to complete the brief mental status interview, understands others and able to make self understood, and was independent in performing activities of daily living (ADL). The MDS indicated the resident received antipsychotic medications during the last seven days.

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A review of the recapitulation of the physician's order for November 2015, indicated the following orders:

1. Geodon 80 milligrams (mg) by mouth two times a day related to unspecified schizophrenia and hashmark episode of psychotic behaviors, ordered on June 20, 2015 (specific target behavior symptom not indicated).
2. Haloperidol Decanoate Sodium Inject 300 mg intramuscularly one time a day every 21 days related to unspecified schizophrenia and hashmark episode of psychotic behavior, ordered on September 3, 2015 (specific target behavior symptom not indicated).
3. Topiramate 100 mg by mouth two times a day related to unspecified schizophrenia and hashmark episode of bipolar behaviors, ordered on November 28, 2015 (specific target behavior symptom not indicated).

A review of the Behavior Monitoring and Interventions for November 2015, indicated the resident is being monitored for pushing and hitting. However, it did not indicate what specific medication is being used to treat what specific behavior symptom.

During an interview on November 23, 2015, at 2:20 p.m., the registered nurse (RN) supervisor and Licensed Vocational Nurse (LVN) 1 reviewed the clinical record and acknowledged that the target behavior symptom for the use of each psychotropic medications was not clearly indicated and specified.

The facility's policy and procedure titled "Behavior Monitoring and Interventions Flow Record

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Instructions" dated July 1, 2014, indicated the purpose of the record is to identify and monitor behaviors and behavior pattern, evaluate effectiveness and monitor side effects of pharmacological interventions, and ensure proper assessment and completion of the MDS.

b. A review of the Admission Record or Resident 7 indicated the resident was admitted to the facility on March 25, 2015, with diagnoses that included schizophrenia and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone).

A review of a care plan dated March 25, 2015, indicated the resident is on psychotropic drugs secondary to behavior/emotional problems manifested by resident having physician ordered psychotropic medications: antipsychotic, antidepressant, mood stabilizer, and antianxiety secondary to resident manifesting behavior/emotional problems that have the potential to affect self, others, and environment secondary to issues with psychosocial well-being. The care plan goal indicated the resident will be free of medication related extra pyramidal reaction and/or falls and increase functional status via the interdisciplinary behavioral plans. The nursing interventions included to give routine and as needed (PRN) medications as ordered by the physician and to monitor laboratory, dietary compliance, environment, and/or medications for possible side effects PRN and report abnormals to physician promptly.

The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated October 8, 2015, indicated the resident was able to complete the brief mental status interview,

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understands others and able to make self understood, and was independent in performing activities of daily living (ADL). The MDS indicated the resident weighed 182 pounds (lbs.) and had no five percent weight loss or weight gain in the last month or ten percent weight loss or weight gain in the last six months.

A review of the recapitulation of the physician's order for November 2015, indicated the following orders:

1. Abilify 10 milligrams (mg) by mouth one time a day related to unspecified schizophrenia and hashmark episode of psychotic behaviors, ordered on October 7, 2015 (specific target behavior symptom not indicated).
2. Depakote ER 1500 mg by mouth at bedtime related to unspecified schizophrenia and hashmark episode of bipolar behavior, ordered on March 28, 2015 (specific target behavior symptom not indicated).
3. Hydroxyzine HCl 50 mg by mouth three times a day related to unspecified schizophrenia and hashmark episode of anxious behaviors, ordered on May 26, 2015 (specific target behavior symptom not indicated).
4. Zyprexa 20 mg by mouth one time a day related to unspecified schizophrenia and hashmark episode of psychotic behaviors, ordered on March 28, 2015 (specific target behavior symptom not indicated).
5. Zyprexa 30 mg by mouth at bedtime related to unspecified schizophrenia and hashmark episode of psychotic behaviors, ordered on March 28, 2015 (specific target behavior symptom not indicated).

A review of the Behavior Monitoring and

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Interventions for November 2015, indicated the resident is being monitored for screaming at others. However, it did not indicate what specific medication is being used to treat what specific behavior symptom.

During an interview on November 24, 2015, at 7:55 a.m., the registered nurse (RN) supervisor reviewed the clinical record and acknowledged that the target behavior symptom for the use of each psychotropic medications was not clearly indicated on the physician's orders and specified.

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS — F 431

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,

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permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility staff failed to mark or label the discontinued medications as "discontinued and subject to destruction". This deficient practice had the potential to result in an inaccurate and unsafe storage of medications.

Findings:

During an inspection of the medication room on November 23, 2015, at 8:21 a.m., there were multiple medications observed inside an unlocked and unlabeled bin stored inside the medication room.

During an interview on November 23, 2015, at 8:21 a.m., Licensed Vocational Nurse (LVN) 1 stated that the medications inside the bin were discontinued medications and need to be returned to the pharmacy and/or destructed. LVN 1 acknowledged that the discontinued medications were not marked or labeled as discontinued.

On November 24, 2015, at 8:30 a.m. the director of nursing (DON) stated that the facility has a new

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F 431	Continued From page 18 locked and labeled container for discontinued medications secured at the administrator's office. The facility's policy and procedure titled "Disposal/Destruction of Expired or Discontinued Medications" dated December 1, 2007, indicated the facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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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 observation, interview, and record review. Licensed Vocational Nurse (LVN) 1 failed to clean and disinfect the blood pressure cuff in between resident use during the medication pass observation. This deficient practice had the potential to spread infections between residents.

Findings:

During a medication pass observation on November 23, 2015, at 10:36 a.m., LVN 1 was observed as he prepared and administered the medications of 17 different residents. LVN 1 checked the blood pressure of four different residents with a manual blood pressure cuff without cleaning and disinfecting the cuff in between resident use. LVN 1 was also observed putting the blood pressure cuff back in the cabinet after use without cleaning and disinfecting it.

During an interview on November 23, 2015, at 12 p.m., LVN 1 stated he does not usually clean and disinfect the blood pressure cuff in between resident use.

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The facility's policy and procedure titled "Cleaning and Disinfecting" revised on May 4, 2015, indicated cleaning and disinfecting of patient care items and environment will be conducted based on risk of infection involved. Non-critical items are objects that do not come into contact with mucus membranes, but do come into contact with intact skin (e.g., blood pressure cuff, glucometers, stethoscope, activity supplies, sensory manipulatives, craft supplies). These items require cleaning between patient use.

F 458 SS=B 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT — F 458

Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that 15 of 19 resident rooms met the 80 square feet (sq. ft.) per residents in multiple resident rooms. These 15 rooms consisted of nine 2-bed rooms and six 3-bed rooms. This has the potential to impede the facility staff's provision of patient care services and impede the ability of any resident in that room to attain his or her highest practicable well-being.

Findings:

On November 23, 2015, between 7:30 a.m. and 8:45 a.m., during a general observation, it was observed 15 of the 19 resident rooms did not meet the requirement of 80 sq. ft. per residents in

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multiple resident rooms. These rooms were Rooms 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 20, 21, 22, and 23. It was further observed these 15 residents in these rooms were able to move freely, nursing staff had adequate spaces to provide care to these residents, and adequate spaces for the beds, chairs, and dressers.

On November 25, 2015, at 8:55 a.m., an interview was conducted with the administrator regarding the 15 resident rooms that did not meet the requirement of 80 sq. ft. per residents in multiple resident rooms. The administrator stated that a room wavier would be submitted for these 15 resident rooms.

On November 25, 2015, at 11:45 a.m., a review of the room waiver letter (dated November 25, 2015 for the 15 resident rooms indicated that these rooms had enough space for each resident's care, dignity and privacy. The waiver letter also indicated that these rooms were in accordance with the special needs of the residents, and would not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver showed the following:

Rm #	# of Beds	Sq. Ft.
3	2	152
4	2	156
5	2	158
6	2	152
7	3	209
9	2	146
10	3	226
12	3	227
14	3	214
16	3	235

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20 2 150
21 2 155
22 2 153
23 2 156

The minimum square footage for a 2-bed room is 160 sq. ft., and a 3-bed room is 240 sq. ft.