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

PRINTED: 04/22/2015
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
	555398	A. BUILDING ______ B. WING ______	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the recertification survey visit from 3/23/15 through 3/26/15 and Extended Survey visit from 4/6/15 through 4/8/15 . The resident census at the start of the survey was 90. Representing the Department: Health Facilities Evaluator Nurse(s): 16538 32718 34236 35287 35388	F 000	**"Preparation 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 the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq".** **This Plan of Correction constitutes the facility's credible allegation of compliance.**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure admission orders were received by the pharmacy for one of twenty-two residents (Resident 14). This failure resulted in two days of missed administration (two doses) of a respiratory medication (Spiriva), which had the potential to cause difficulty breathing for Resident 14. Findings: A review of the clinical record for Resident 14 indicated he was admitted on 1/10/15, with diagnoses that included chronic airway	F 281	**F 281 483.20(k)(3)(i) Services Provided Meet Professional Standards** It is the practice of this facility to provide services that meet professional standards. **How Corrective Action will be accomplished for residents affected** Resident 14 has been discharged from the facility prior to survey.	5/8/15

RECEIVED
MAY 07 2015
Licensing & Certification
East Bay District Office

Acceptable POC 5/11/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5.5.15

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 281	Continued From page 1 obstruction (a lung condition that causes difficulty with breathing), congestive heart failure, and high blood pressure. A review of physician ' s orders dated 1/10/15, indicated Resident 14 was to receive the inhaled respiratory medication, Spiriva, once a day, for the chronic airway obstruction. A review of the Medication Administration Record (MAR) for Resident 14, indicated Spiriva was not given 1/11/15 or 1/12/15. A review of Resident 14 ' s " Progress Notes, " dated 1/11/15, indicated licensed nursing staff believed pharmacy was in the process of delivering the admission medications. A note dated 1/11/15, at 12:11 p.m., by Licensed Vocational Nurse 2 (LVN 2), indicated, " following Pharmacy for pending meds. " A note dated 1/11/15, at 9:57 p.m., by Registered Nurse 1 (RN 1) indicated, " Med is not available. Waiting for pharmacy delivery. " During a phone interview on 4/3/15, at 10 a.m., the Pharmacy Compliance Supervisor (PCS) stated a face sheet (a form that includes resident data such as name, birthdate, diagnosis, and payment source) had been received by the pharmacy on 1/11/15. She stated the face sheet was faxed back to the facility with a request for medication orders on 1/11/15, but that no fax was received until 1/12/15 at 12:21 a.m., when the medication orders were received by the pharmacy. A review of a copy of a fax to the pharmacy titled, " New Admissions Only, " indicated a date of 1/12/15, Resident 14 ' s name, " page 4 of 4, "	F 281	1. All medications for new admissions are now being processed by the ~~Hayward~~ Pharmacy rather than the ~~local~~ location. Delivery times have been revised to meet the needs of the facility. 2. Nurses have been re-educated on 3/16/15, 3/25/15, 3/27/15, 4/15/15, and 4/16/15 by the Regional Clinical Director, Director of Nursing and the ~~Omnicare~~ Pharmacy Nurse regarding the medication ordering process including how to order medication and steps to follow when a medication is not delivered in time for the required dosage time including calling the pharmacy, using Omniview to verify that a script has been received and processed, and notifying the Director of Nurses, and using the e-kit as appropriate to administer medication as ordered by the physician. If the medication cannot be delivered by the next dosage time, the nurse will notify the physician for further orders. 3. DON and/ or Nursing Supervisor will verify that all meds have been delivered and administered in a timely manner daily as a part of the Daily Stand Up Meeting.	

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F 281	Continued From page 2 and the note, " Please see attached orders and send ASAP. " Copies of three pages of physician ' s admission orders for Resident 14 were attached to the fax copy. During an interview on 4/8/15, at 11:45 a.m., the Pharmacy Consultant 1 (PC 1) stated the pharmacy would not be concerned about receipt of a resident face sheet without accompanying admission orders, because sometimes pre-admitted residents would have admission delayed or cancelled. During an interview 4/8/15, at 8:55 a.m., the Regional Clinical Director (RCD) stated the facility usually sent physician orders with the resident face sheet to the pharmacy on admission. She also stated the facility had no permanent record of admission faxes sent to the pharmacy. A review of MedlinePlus (MedlinePlus is the National Institutes of Health's Web site for patients and their families and friends), "Tiotropium [chemical name of Spiriva]," (accessed 4/14/15) indicated, "Tiotropium is used to prevent wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) .... Tiotropium controls COPD but does not cure it. It may take a few weeks before you feel the full benefits of tiotropium. Continue to take tiotropium even if you feel well. Do not stop taking tiotropium without talking to your doctor." [http://www.nlm.nih.gov/medlineplus/druginfo/meds/a604018.html] A review of the facility policy titled, "Physician Orders, Accepting, Transcribing, and	F 281	4. If any medication is not received or administered as required, the pharmacy will be asked to research the missing medication and do root cause analysis, and make corrective action as required. **Identification of Residents with the Potential to be Affected:** All new admissions have the potential to be affected. The following process will be followed for all new admissions: 1. All medications for new admissions are now being processed by the ~~Hayward~~ Pharmacy rather than the ~~Local~~ location. Deliveries have been rerouted so that facility will receive orders early in the delivery run rather than last. 2. Charge Nurses will order medications from the pharmacy as soon as practical following the Omnicare ordering procedures and will fax orders to the pharmacy including any written scripts for dispensing. The following steps will be completed when a medication is not delivered in time for the required dosage time:	

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F 281	Continued From page 3 Implementing," dated July 2008, reviewed 8/12/14, indicated, " 2. Implementation of Orders ...Fax all new medication orders and changes/discontinuations to the pharmacy ..." A review of the facility policy titled, "Delivery and Receipt of Routine Deliveries," dated May 2010, reviewed 8/12/14, indicated, "2.5. If any item ordered is not received, check for a communication slip indicating: ...any other communication explaining the reason a medication or item was not delivered. Facility should contact Pharmacy if Facility requires an explanation for the missing items or medications ..."	F 281	a) Call the pharmacy to check on delivery time or use Omniview to verify that a script has been received and processed and scheduled for delivery. b) Using the e-kit as appropriate for meds available in the e-kit c) Notify the Director of Nurses, that medication has not been received and to administer medication as ordered by the physician. d) If the medication cannot be delivered by the next dosage time, the nurse will notify the physician for further orders. e) DON will track any delivery issues using a QAPI tool **Measures to Prevent Recurrence**: 1. Licensed Nurses have been re-educated regarding Medication Ordering and Processing on 3/16/15, 3/25/15, 3/27/15, 4/15/15, and 4/16/15 by the Regional Clinical Director, Director of Nursing and the Omnicare Pharmacy Nurse. 2. DON and/or Nursing Supervisor will verify that all meds have been delivered and administered in a timely manner daily as a part of the Daily Stand Up Meeting Monday-Friday. Any irregularities will be immediately corrected and tracked	
F 309 SS=G	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, 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 facility failed to adequately assess the pain levels and provide the prescribed pain medications for two of 22 sampled residents (15, 17) resulting in the residents experiencing pain without relief and failed to ensure arm splints were ordered for one additionally sampled resident (24) resulting in a delay of treatment for the Resident's carpal tunnel syndrome.	F 309		

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F 309	Continued From page 4 1. For Resident 17's chronic pain, the facility failed to ensure that they had the pain medication (Morphine ER 100 milligrams[mg.] orally) as ordered for Resident 17's pain and failed to notify the resident's physician when Morphine was not available resulting in Resident 17 experiencing unrelieved pain. 2. For Resident 15, the facility failed to provide scheduled pain medication (Oxycodone , a narcotic pain reliever) on eleven occasions, that resulted in inadequate pain control and discomfort from symptoms due to not getting the medication. 3. For Resident 24, the facility failed to ensure that arm splints were ordered to provide pain relief for the resident's bilateral carpal tunnel syndrome (numbness, pain, weakness in hands because of pressure on the median nerve of the wrist). Findings: 1. On 3/24/15 at 8:30 a.m. review of the clinical record showed Resident 17 was admitted on 3/18/15, after a left hip replacement. The resident had a history of bilateral (both) hips osteoarthritis (bone joints disease and swelling) and spinal stenosis of the lumbar spine (Spinal stenosis is the narrowing of spaces in the spine (backbone) which causes pressure on the spinal cord and nerves.) Physician's order dated 3/18/15, included the following : a. Pain monitoring scale: Monitor level of pain every shift: 0 = None (no pain)	F 309	using Medication QAPI tool for 90 days. 3. If any medication is not received or administered as required, the pharmacy will be asked to research the missing medication and do root cause analysis, and make corrective action as required and communicate findings with the DON for follow-up. This information will be recorded on the QAPI Tool. **Monitoring Corrective Action and Responsibility:** 1. DON will report the findings of the QAPI tool and any trends to the QA&A Committee for recommendation and follow-up 2. Consultant Pharmacist will review as part of the Monthly Drug Regimen Review and will include recommendations in the Monthly Pharmacy Consultant Report. **Date of compliance:** 5/08/2015 **F309 483.25 Provide Care/ Services for Highest Well Being** This facility is committed to providing all our residents necessary care and services to attain and maintain the highest practicable overall well-	

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F 309	Continued From page 5 1-3 = Mild pain 4-6 = Moderate pain 7-10 = Severe pain every shift, start date 3/18/15 , 3:00 p.m. b. Morphine Sulfate ER (Extended Release) (narcotic pain reliever)100 milligram tablet. Give 1 tablet by mouth every 8 hours for pain management. Start date 3/18/ 2015 at 22 (10 pm) Facility's every eight hour medication schedule was 6 a.m.; 2 p.m.; 10 p.m. c. Percocet (pain reliever) tablet one tablet every 6 hours, as needed, for moderate pain. d. Percocet to give 2 tablets every 6 hours for severe pain. On 3/26/15 at 8:00 a.m., during an interview, RN 3 (Registered Nurse 3) said he assisted RN 4 with the admission of Resident 17 between 5:00 p.m. and 6:00 p.m. on 3/18/15. On 3/26/15 at 9:16 a.m., during a telephone interview, RN 4 said she went to check Resident 17 after 9 p.m. (on 3/18/15). Resident 17 was in pain and requested pain medication. RN 4 did not remember what Resident 17's pain level was. RN 4 said she told the medication nurse to give the resident two tablets of "Percocet (pain reliever) or Norco (pain reliever)." RN 4 was not sure which pain reliever was ordered but was sure it was not Morphine because there was no Morphine tablets available at that time. During the interview, RN 4 was asked if the physician was notified that Morphine was unavailable, RN 4 stated that she did not notify	F 309	being, in accordance with the comprehensive assessment and plan of care. **How Corrective Action will be accomplished for residents affected:** Resident 17 has been discharged from the facility. All pain medications were on board and resident was able to participate in therapy and be discharged home per plan. Resident 15 is currently receiving medications as ordered from the physician. MD has been notified of the need to sign written requests from the pharmacy for refills of medication. Resident 24 has been provided with the appropriate splint and is wearing the splint as desired. **Identification of Residents with the Potential to be Affected:** All residents who experience pain have the potential to be affected by this deficiency.	5/8/15

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F 309	Continued From page 6 the physician. Review of Resident 17's admission record indicated that pain assessment was done on 3/18/15 at 11:38 p.m., several hours after admission. The assessment indicated that Resident 17 verbally described his pain intensity and was assessed at level 7. Resident 17 was in severe pain. On 3/26/15 at 9:26 a.m. during an interview, LVN 6 (Licensed Vocational Nurse 6), who was assigned to take care of Resident 17 on 3/19/15 night shift, stated that the report and instructions given to her by the afternoon shift (3/18/15) licensed nurse was that Resident 17's Morphine tablets were unavailable and not delivered by the pharmacy. Resident 17 missed his 10:00 p.m. dose of Morphine. LVN 6 gave Resident 17 two Percocet tablets for his pain at 1:30 a.m. on 3/19/15 . At that time according to LVN 6, Resident 17's pain level was 8 (severe pain) . The documentation did not show that Resident 17's pain level was assessed after Percocet tablets were administered. Review of Resident 17's MAR (Medication Administration Record) dated 3/18/15, indicated that Resident 17's pain level was 8 (severe pain) during the afternoon 3/18/15 and 3/19/15 night shift. Morphine was not administered until 3/19/15 at 5:00 a.m. eleven hours after admission. On 3/26/15 at 9:35 a.m. during an interview, Resident 17 described how "miserable" he was and in "so much pain and discomfort" on evening of 3/18 and the following night. He stated that he begged and requested the nurses to call his doctor and "do something, they seem to not understand how bad these pains are". The only answer he got was that "they(pharmacy)" did not	F 309	Physician orders will be utilized to determine resident who have potential to be affected. Residents with current pain medication orders were reviewed to ensure pain assessments, Medication Administration Records and care plans were completed and any identified issues were corrected as needed. Residents physician orders were reviewed to ensure therapy orders were all communicated to the therapy department. 1. All medications for new admissions are now being processed by the Hayward Pharmacy rather than the Gading location. Deliveries have been rerouted so that facility will receive orders early in the delivery run rather than last. 2. Charge Nurses will order medications from the pharmacy as soon as practical following the admission using Omnicare ordering procedures and will fax orders to the pharmacy including any written scripts for controlled substances for dispensing. Refills will be ordered in a timely manner to ensure a continuous supply of controlled medications to treat Residents pain.	

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F 309	Continued From page 7 "deliver" his Morphine. Instead he was given Percocet tablets . Resident 17 said that he was on "chronic pain" (persistent pain refers to a pain state that continues for a prolonged period of time or recurs more than intermittently for months or years) management at home and prior to his surgery. He explained that when he misses a dose of Morphine he cannot manage his pain and the Percocet medication is only for breakthrough pain in between his doses of Morphine. During the interview, Resident 17 said the nurses told him Morphine was delivered at around 2 a.m., (3/19/15) the morning after he was admitted but they did not give it to him because it is not time yet. The nurse did not give him Morphine until 5 a.m. On 4/8/15 at 11:05 a.m., during an interview, two of the facility pharmacy consultants (PC1 and PC2), confirmed that Resident 17's Morphine ER was delivered on 3/19/15 at 2:57 a.m. as confirmed by review of the shipping manifest On 3/26/15 at 2:45 p.m. during a telephone interview, Physician 1 stated Resident 17 was on high intravenous dose of Dilaudid (opiod narcotic pain reliever) after Resident 17's hip surgery, therefore it is "very important" for the resident's chronic pain management to administer the prescribed morphine on time. Physician 1 stated that when the facility failed to administer the Morphine for any reason, the nurses should have notified the attending physician or the on call physician so that they can give the nurses appropriate instructions on what to do. Physician 1 stated the facility did not notify him or the on-call physician about the Morphine not being available.	F 309	The following steps will be completed when a medication is not delivered in time for the required dosage time: a) Call the pharmacy to check on delivery time or use Omniview to verify that a script has been received and processed and scheduled for delivery. Inform the pharmacy of need for drug by next dose time. b) Using the e-kit as appropriate for meds available in the e-kit. c) Notify the Director of Nurses, that medication has not been received and to administer medication as ordered by the physician. d) If the medication cannot be delivered by the next dosage time, the nurse will notify the physician for further orders. e) DON will track any delivery issues using a QAPI tool. **Measures to Prevent Recurrence** 1. Licensed Nurses have been re-educated regarding Medication Ordering and Processing on 3/16/15, 3/25/15, 3/27/15, 4/15/15, and 4/16/15 by the Regional Clinical Director, Director of Nursing and the Omnicare Pharmacy Nurse.	

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F 309	Continued From page 8 2. A review of the clinical record for Resident 15 indicated he was admitted to the facility 7/8/14, with diagnoses that included chronic pain syndrome, infection of the brain, and hemiplegia (paralysis of one side of the body). The Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 7/18/14, indicated Resident 15 understood was what said to him, and was able to be understood, with a Brief Interview for Mental Status score of 10. (BIMS, an assessment tool for a resident's orientation to time, and capacity to remember. The BIMS range is from 0-15, with zero the most impaired. A score of 10 is an indication of moderate impairment.) Resident 15 required extensive assistance to get out of the bed or use a wheelchair. The MDS further indicated Resident 15 was on scheduled pain medication, but still had occasional pain at a level of eight on a scale of one to ten (with ten the worst pain). A review of the physician orders for Resident 15, dated January 2015, indicated the following pain medication regimen of: 1) Oxycodone, 10 mg(milligrams) to be given orally every 6 hours around the clock; 2) Fentanyl via transdermal (skin) patch that delivered 25 micrograms per hour, to be changed every three days, and 3) Morphine Sulfate 2 mg to be given every four hours, if needed for pain. Nursing staff was to monitor and record Resident 15's level of pain every shift on the "Medication Administration Record (MAR), Pain Monitoring Scale.". The MAR indicated a 0-10 scale was to be utilized: "0=none; 1-3=mild pain; 4-6=moderate pain; 7-9=severe pain; 10=worst pain." A review of the care plan for Resident 15, created 7/24/14 and revised 3/4/15, with the focus of,	F 309	2. Licensed Nurses were re-educated regarding Pain Management and Controlled Drug Procedures on 3/16/15, 3/25/15, 3/27/15, 4/15/15, and 4/16/15 by the Regional Clinical Director, Director of Nursing and the Omnicare Pharmacy Nurse. 3. Charge nurses will have primary responsibility for ensuring that all meds are available for administration and will notify the pharmacy and the DON prior to any missed doses. The following steps will be completed when a medication is not delivered in time for the required dosage time: a) Call the pharmacy to check on delivery time or use Omniview to verify that a script has been received and processed and scheduled for delivery. Inform the pharmacy of need for drug by next dose time. b) Using the e-kit as appropriate for meds available in the e-kit c) Notify the Director of Nurses, that medication has not been received and to administer medication as ordered by the physician. d) If the medication cannot be delivered by the next dosage	

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F 309	Continued From page 9 "The resident is on Pain Medication Therapy," indicated the first intervention as, "Administer medication as ordered ie Oxycodone every 6 hrs [hours], Fentanyl patch, Morphine sulfate prn [as needed]." During review of the clinical record for Resident 15, the MAR, dated 1/1/15 through 1/3/15, indicated 8 doses of oxycodone were not given as ordered: 1/1/15 at 6 a.m., noon, and 6 p.m.; 1/2/15 at midnight, 6 a.m., and noon; 1/3/15 at noon, and 6 p.m. The six consecutive doses missed on 1/1/15 and 1/2/15 resulted in a 42 hour gap without oxycodone administration, followed by administration of three doses as ordered (1/2/15 at 6 p.m., 1/3/15 at midnight, and 1/3/15 at 6 a.m.), followed by another 18 hour gap from two missed doses (1/3/15 at noon, and 6 p.m.). The MAR further indicated that during this same time period, Resident 15 received the "as needed for pain" medication, morphine sulfate, eleven times: two doses on 1/1/15, six doses on 1/2/15, and three doses on 1/3/15. During the remaining 28 days of January, Resident 15 received a total of ten doses of morphine, with no more than 2 doses on any single day. The MAR indicated that on 1/10/15, the only day in January with two morphine doses administered (one at 9:31 a.m., one at 6 p.m.), the oxycodone was not given at 6 p.m. During an interview on 4/7/15, at 1:15 p.m., Registered Nurse 1 (RN 1) stated there was no oxycodone available on 1/2/15, and 1/3/15 for Resident 15, and the pharmacy would not release the e-kit oxycodone for use; she left a message with the physician to inform him of the need to provide authorization to the pharmacy for oxycodone. RN 1 stated that Resident 15 had the capacity to tell his level of pain, and would ask for morphine when he had pain.	F 309	time, the nurse will notify the physician for further orders. e) DON will track any delivery issues using a QAPI. 4. DON and/or Nursing Supervisor will verify that all needed meds were delivered in Daily Stand Up and any delivery issues will be immediately corrected and tracked using the QAPI tool. 5. Omnicare will be asked to determine cause of delivery failure and report back to the facility which will also be tracked on the QAPI tool. **Monitoring Corrective Action and Responsibility:** 1. Consultant Pharmacist will verify during the Monthly Regimen Review that all meds were delivered and available for administration and will reflect any issues in the monthly report. 2. DON will present findings of the QAPI tool at QA&A for review and recommendations. 3. Administrator with the QA&A Committee will have oversight of Pharmacy Services. **Date of compliance:** 5/8/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 309	Continued From page 10	F 309		

During review of the January 2015 MAR for Resident 15, the "Pain Monitoring Scale," indicated presence of pain across all seven nursing shifts from 3 p.m. on 1/1/15, to 3 p.m. on 1/3/15. Five of the seven shifts recorded pain at level 5 (moderate pain). During a review of the Nursing Progress Notes dated 1/2/15 at midnight, 4:03 a.m., and 8 a.m., nurses noted pain at level six out of ten.

A review of the March 2015 MAR for Resident 15, indicated three consecutive doses of oxycodone were not given: 3/18/15 at noon and 6 p.m., and 3/19/15 at midnight. The oxycodone schedule was resumed with the 6 a.m. dose on 3/19/15, with 24 hours lapsed time between oxycodone doses. The March 2015 MAR indicated three doses of morphine sulfate were given 1/19/15 between midnight and 8:30 a.m., with pre-medication pain levels noted as six, seven, and five. At no other time during the month (from 3/7/15 through 3/24/15) were more than two doses of morphine given in a single day.

During an interview on 3/26/15, at 8:05 a.m., Licensed Vocational Nurse 1 (LVN 1) stated she was aware of Resident 15's missed doses on 3/18/15. She stated she had asked the physician to write a continuation letter for the oxycodone the previous week, but he had not done so. She also sent a refill request to the pharmacy for the oxycodone on 3/13/15. On 3/18/15, the 6 a.m. dose was the last oxycodone given. LVN 1 documented the missed noon dose, and called the pharmacy for the current status of the oxycodone. She was informed that the pharmacy was still waiting for the doctor to complete the continuation letter. LVN 1 stated she then called the doctor, who said he had completed the continuation letter, and the pharmacy should be delivering the medication; he didn't authorize use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 309	Continued From page 11	F 309		

of the emergency kit (e-kit) for the missed oxycodone. LVN 1 stated she had medicated Resident 15 with morphine at 10 a.m., and he appeared comfortable before she left at 3 p.m.
A review of an e-mail to the Regional Clinical Director (RCD) from the Back End Manager (BEM) of the pharmacy, dated 3/26/15, at 1:04 p.m. (received by the RCD on 3/26/15, at 3:30 p.m.), indicated the pharmacy had received the continuation authorization letter for the oxycodone for Resident 15 on 3/17/15, at 5:20 p.m., and delivery of the oxycodone was arranged for 3/19/15.
A review of the March 2015 MAR for Resident 15, "Pain Monitoring Scale," indicated presence of pain at level six and five during the two nursing shifts from 3/18/15 at 11 p.m., to 3/19/15 at 3 p.m. A review of the Nursing Progress Notes dated 3/19/15 at 4:12 a.m., indicated pain at level seven.
During a review of the clinical records for Resident 15, "Progress Notes," dated 3/18/15, at 7:04 p.m., indicated, "Med not available, and 3/19/15 at 12:47 a.m., indicated, "Waiting for medication delivery."
During a review of the clinical record for Resident 15, the March 2015 MAR indicated Resident 15 received three oral doses of 2 mg morphine sulfate during the time of missed oxycodone doses from 3/18/15 to 3/19/15. The MAR further indicated a documented pain score of 6 (moderate pain) for the shift beginning at 11 p.m. on 3/18/15, and ending 7:30 a.m. on 3/19/15.
During a review of the clinical record of Resident 15, the "Progress Notes," dated 3/19/15, at 4:12 a.m., indicated a pain score of seven (severe pain).
During an observation and concurrent interview on 3/26/15, at 9:25 a.m., Resident 15 was lying in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 309	Continued From page 12	F 309		

bed, with the head of the bed elevated, watching television. Resident 15 verbally responded to questions, and although his speech was slightly garbled, he was understandable. He said it was painful when he missed doses of oxycodone the previous week [week of March 15-22]. Resident 15 said both his legs hurt, and he "felt bad." He stated he was given doses of morphine during the time of the missed oxycodone doses, but that they didn't really take away the pain. He said he had felt "that bad" one other time, sometime after Christmas, when he also didn't receive several doses of oxycodone. Resident 15 said it was hard to speak and took so much energy that he preferred for his Responsible Party (RP 1) to speak for him during extended conversations.
During an interview on 3/26/15, at 9:05 a.m., the RP 1 stated she visited daily and assisted with daily care needs (e.g., eating, repositioning, grooming). She stated that Resident 15 had missed doses of the oxycodone on March 18 and 19. When RP 1 visited on the morning of 3/19/15, Resident 15 said he didn't feel right overnight, and thought he might have been going through withdrawal. RP 1 said she had told staff he was in active withdrawal a couple months earlier, when doses of the oxycodone had been missed. She stated that on the earlier occasion of missed oxycodone he was very distressed. She said he had constant jitters, and kept grabbing the bed, saying, "Something's not right." She said he didn't look or act right, and she gave the example that he refused his favorite snack (a lollipop).
A review of Lexi-Comp (an on-line drug reference for the healthcare industry), "Oxycodone," (accessed 4/6/15) indicated that oxycodone and morphine were classified as opiate agonists (a class of drugs that stimulate opiate receptors and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

(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 309	Continued From page 13	F 309		

effectively relieve pain without producing loss of consciousness), which are known to have the risk of physical dependence with continued administration. Lexi-Comp also indicated, "Individuals who are physically dependent on opiate agonists may remain relatively asymptomatic as long as they are able to maintain their daily opiate agonist requirement ... Physical dependence results in withdrawal symptoms in patients who abruptly discontinue the drug ...The abstinence syndrome varies in severity according to the specific drug and the amount of drug the patient has been taking ...In general, the shorter the onset and duration of action of the drug, the greater the intensity and rapidity of onset of withdrawal symptoms." According to Lexi-Comp, for oxycodone, "the analgesic effect occurs within 10-15 minutes, reaches its maximum in 30-60 minutes, and persists for 3-6 hours." [http://online.lexi.com/lco/action/doc/retrieve/docid/250/413845#mono-ref-nested]

A review of DailyMed (an online resource from the National Library of Medicine, that is the official provider of FDA label information), "Oxycontin/oxycodone hydrochloride tablet," (accessed 4/6/15) indicated, "Patients considered opioid tolerant are those who are taking at least ... 30 mg oral oxycodone/day ...for one week or longer."

A review of the 2015 January MAR for Resident 15, indicated that the orders for the oxycodone and morphine had been in effect since 7/17/14, with no change in dosage. A review of Resident 15's physician orders for both January and March of 2015, indicated a dose of two milligrams morphine sulfate as needed for pain, was administered during the times of missed oxycodone doses. A review of Lexi-Comp,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 309	Continued From page 14	F 309		

"Oxycodone," accessed 4/6/15, indicated a 15 milligram dose of oral morphine sulfate would be needed to provide the equivalent pain relief provided by a ten milligram dose of oxycodone. A review of MedlinePlus (the National Institute of Health website for information on health, medications, and diseases), "Oxycodone," (accessed 4/6/15) indicated: "Do not stop taking oxycodone without talking to your doctor. If you stop taking this medication suddenly, you may experience withdrawal symptoms such as restlessness, watery eyes, runny nose, sneezing, yawning, sweating, chills, muscle or joint aches or pains, weakness, irritability, anxiety, depression, difficulty falling asleep or staying asleep, cramps, nausea, vomiting, diarrhea, loss of appetite, fast heartbeat, and fast breathing. Your doctor will probably decrease your dose gradually."

3. Review of clinical record showed Resident 24 was admitted on 3/15/11 and re-admitted on 10/24/14 with diagnoses that included paraplegia (paralysis of the lower half of the body) due to spina bifida (congenital disorder caused by incomplete development of the spinal cord). During observation and concurrent interview on 3/23/15 at 9:10 a.m., Resident 24 moved around the facility in an electric wheelchair with a joystick controlled by Resident 24's right hand. Resident 24 stated that the nurse practitioner ordered wrist splints last week and as of 3/23/15, no one had supplied them or discussed obtaining them with him.

Review of Resident 24's clinical record on 3/23/15, showed a physician's order dated 3/16/15 to supply Resident 24 with wrist splints to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 309	Continued From page 15	F 309		

treat bilateral over use carpal tunnel syndrome (numbness, pain, weakness in hands because of pressure on the median nerve of the wrist).
Licensed Vocational Nurse (LVN 4) noted this order on 3/16/15.
During an interview on 3/25/15 at 9:50 a.m., LVN 4 stated she noted the order on 3/16/15 then entered it into the computer for rehab services to fit resident with wrist splints. LVN 4 further stated she spoke to the Director of Rehab (DR) and notified her of the order.
During an interview on 3/25/15 at 3:55 p.m. the Director of Rehab (DR) stated she was not notified of the order for wrist splints until 3/23/15. She stated physical therapy and occupational therapy orders are verbally communicated to the department by the physician or the nursing staff. She stated no one in the therapy department was notified of these orders on 3/16/15.
During an interview on 3/24/15 at 3:30 p.m., the Occupational Therapist (OT) stated his evaluation of Resident 24 on 3/23/15 showed Resident 24 had 3 plus of 5 weakness (5 of 5 would indicate normal strength) to wrists and hands and had pain level of four of ten (moderate pain) which "gets worse" (increased to 7 of ten, severe pain) with wrist flexion.
During an observation and concurrent interview on 3/26/15 at 11:30 a.m., Resident 24 was in bed. He reported he had not received the splints. He stated the facility had to order a larger size because they did not have splints that fit him available in the facility. He stated he is "taking it easy" and not using his electric wheelchair because the pain and numbness in his hands and wrist increased with movement of his hands operating his wheelchair.
The National Institute of Health's Carpal Tunnel Syndrome Fact Sheet showed, "Early diagnosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 309	Continued From page 16 and treatment are important to avoid permanent damage to the medial nerve. Immobilizing the wrist in a splint avoids further damage from twisting and bending."	F 309		
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 and interview the facility failed to provide an environment that was free of accident hazard for one (Resident 26) random sampled resident. Failure had the potential for the resident to get hurt. Findings: During the initial tour of the facility with CSC 1 (Central Supply Clerk 1) on 3/23/15 at 8:30 a.m., a black colored telephone was observed on top of Resident 26 overhead light with the telephone cord hanging by the right side of resident's bed. Resident 26 was interviewed she stated that she was looking for her phone, did not have an idea who placed it on top of her overhead light. Resident 26 expressed the fear and thought of	F 323	**F323 483.25(h) Free of Accident Hazards/ Supervision /Devices** The facility is committed to providing an environment as free of accident hazards as possible. **How Corrective Action will be accomplished for residents affected** Resident 26-The phone was moved immediately during survey. **Identification of Residents with the Potential to be Affected:** Any resident with something stored on the overhead light has the potential to be affected. **Measures to Prevent Recurrence:** 1. Staff was re-educated regarding safety and items stored on overhead lights on 4/15/15, 4/16/15 by the Administrator and DON. **Monitoring Corrective Action and Responsibility:** 1. Department Heads will make assigned room rounds daily as part of Quality Rounds to observe for anything stored on top of overhead lights.	5/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 323	Continued From page 17 the telephone falling into her head.	F 323	2. Results of Quality Rounds will be reported at Daily Stand Up Meeting Monday to Friday. 3. Administrator will track and trend Quality Rounds Forms to monitor compliance. 4. Administrator will report trends to the QA&A Committee for follow-up and recommendations. **Date of compliance:** 5/8/2015 **F371 483.35(i) Food, Procure, Store, Prepare, Serve-Sanitary** It is the policy of this facility to store, prepare, distribute, and serve all food under sanitary conditions. **How Corrective Action will be accomplished for residents affected:** No residents were listed in the Statement of Deficiencies. **Identification of Residents with the Potential to be Affected:** All residents have the potential to be affected by the deficient practice.	
F 371 SS=E	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, interview, and record review, the facility failed to provide a clean, hygienic kitchen environment by: 1. failing to clean three of three steam table sinks. 2. failing to ensure Dietary Services Aide 1 (DSA 1) wear a hair net to contain all hair on two occasions. These failures had the potential to result in contamination of food, and could result in foodborne illness for residents that eat food from the kitchen. Findings: 1. During a kitchen tour observation on 3/23/15, at 8:05 a.m., the bottoms of three of the three metallic, silver colored steam table sinks were diffusely covered with a gray residue. During an interview on 3/23/15, at 8:05 a.m., the	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 371	Continued From page 18 Dietary Supervisor (DS) stated the evening cook was responsible for emptying the water, and scrubbing the steam table sinks every night. She further stated the residue was on the bottom of the sinks because the cooks must not have been scrubbing the sinks as required. During an observation on 3/24/15, at 3 p.m., the bottoms of the three steam tray sinks had been cleaned except for a one-inch pattern of brown residue that remained in grooves on the bottoms of all three sinks. During an interview on 3/25/15, at 3 p.m., the DS stated that the sinks had been scrubbed as clean as possible, and the remainder of the residue would require chemical cleaning. The facility dietary manual policy, "Sanitation of Dietary Department," dated August 2008, indicated, " Policy Statement: The Dietary staff will maintain the sanitation of the Food Service department through compliance with a written, comprehensive cleaning schedule. Procedure: l. The food service director will record all cleaning and sanitation tasks for the department. 2. Tasks will be designated to be the responsibility of specific positions in the department. 3. All tasks will be addressed as to the frequency of the cleaning. 4. A cleaning schedule will be posted weekly for all cleaning tasks, and employees will initial tasks as completed. " 2. During a kitchen observation on 3/23/15, at 8:25 a.m., and 3/24/15, at 11 a.m., DSA 1 wore a hair net that did not contain hair at the back of the head, from ear to chin level. During an interview on 3/24/15, at 11 a.m., the DS	F 371	**Measures to Prevent Recurrence:** **Hairnets** 1. The Dietary Aide with hair partially covered by a hair net was immediately instructed by the Dietary Supervisor to cover hair completely with a hair net. 2. All other dietary staff was spot checked by the Dietary Supervisor to ensure that hair was completely covered with hair nets. Dietary Supervisor reminded the dietary staff to use the mirror provided in the kitchen to ensure that hair nets cover all of hair. 3. Dietary staff was re-educated by the Dietary Supervisor on 3/30/15 and 4/1/15 regarding the facility's policy for hair net/ dress code. **Steam table** 1. The three steam tables were deep cleaned completely on 4/1/15. No residues were identified on the steam table after deep cleaning. 2. Dietary staff was in-serviced by the Dietary Supervisor on facility's policy and procedure for deep cleaning steam tables on 3/3/0/15 and 4/1/15. 3. Consultant Dietitian shall include the cleanliness of the steam tables in the monthly sanitation report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 371	Continued From page 19 stated hair nets should cover all the hair, and told DSA 1 to adjust the hair net so that all the hair was covered. The DS stated she had informed DSA 1 to adjust the hair net on 3/23/15, also, as it was very important to cover all hair to protect the food from hair contamination. A review of the, "Food Code 2013: Recommendations of the United States Public Health Service, Food and Drug Administration Food Guide of 2013, Hair Restraints, 2-402.11 ...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD ..."	F 371	Monthly QA shall include findings from the consultant RD. **Monitoring Corrective Action and Responsibility:** 1. Dietary Supervisor shall conduct routine spot checks to ensure continued compliance with hair net placement. Consultant Dietitian shall include hair net compliance in the monthly sanitation report. Monthly QA shall include findings from the Dietary Supervisor and the consultant RD.	5/8/15
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 411	2. Dietary Supervisor shall conduct routine spot checks to ensure continued compliance with cleanliness and sanitation of steam tables. Consultant Dietitian shall steam table cleanliness in the monthly sanitation report. Monthly QA shall include findings from the Dietary Supervisor and the consultant RD. **Date of compliance**: 5/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 411	Continued From page 20	F 411		

interview, the facility failed to arrange for emergency dental services for one of 22 (16) sampled residents, resulting in Resident 16 having a broken tooth which interferred with his chewing food.
Finding:
Review of the clinical record on 3/24/15 showed Resident 16 was admitted on 3/5/15 with diagnoses that included congestive heart failure (inability of the heart to effectively pump blood in the body) and hospice care (care for persons who are terminally ill). A review of the Admission Minimum Data Set dated 3/12/15 showed that Resident 16 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that Resident 16's mental ability was intact.
During an observation and concurrent interview on 3/23/15 at 3:05 p.m. and on 3/25/15 at 2:20 p.m., observation showed Resident 16 had a small wound on his upper lip, and a larger wound on the inside of his lower lip. The lower half of the right upper tooth was missing. His left upper tooth had about a quarter of the tooth broken off. Resident 16 stated he stumbled over the wheel of his bed and fell on 3/21/15 and broke 2 teeth and cut his upper lip and the inside of his lower lip. Resident 16 stated he had a large amount of bleeding from his mouth and it was painful. And, while he was sitting up in bed, a staff member came and only gave him a towel. Resident 16 stated he continued to have mouth pain and difficulty biting down on food; therefore, he has been eating less. Resident 16 stated, "My smile is messed up, " and that no one at the facility offered him a referral to a dentist.
Review of The American Association of Endodontists under, "Traumatic Dental Injuries" showed, "any dental injury, even if apparently mild, requires examination by a dentist or

F-411 483.55(a) Routine/ Emergency Dental Services in SNFs

It is the policy of this facility to provide routine and emergency dental services to meet the needs of each resident.

How Corrective Action will be accomplished for residents affected:

Resident 16 has been discharged from the facility. Resident was immediately referred to dental services when he expressed a need for dental services. He had stated at the time of the fall that he did not need to see the dentist.

Identification of residents with the potential to be affected:

All residents who experience dental injuries could be affected by the deficient practice.

Measures to Prevent Recurrence:

1. Licensed staff and social services staff was in-serviced on 4/15/15 and 4/16/15 regarding referral process for the dentist when dental injuries occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 411	Continued From page 21 endodontist immediately." During an interview on 4/7/15 at 1:10 p.m., RN 1 stated she was told on 3/21/15 by Certified Nursing Assistant (CNA) 1 that Resident 16 had fallen. When RN 1 entered Resident 16's room, Resident 16 was sitting on the side of his bed. She checked him for injury. RN 1 said Resident 16 had a small cut on his lip and a small amount of bleeding. She confirmed she did not check inside Resident 16's mouth. She faxed a message to the doctor regarding the fall but did not include the resident's name. Review of Resident 16's clinical record showed a facility FAX cover sheet dated 3/21/15 that was addressed to a physician with information about the fall. It did not include Resident 16's name nor was there any documentation that the fax was received or acted on by the physician.	F 411	**Monitoring Corrective Action and Responsibility:** 1. Changes of condition that may result in the need for a dental referral will be reviewed as part of Daily Stand Up and Social Services will follow up with referrals as necessary. 2. Social Services Director is Responsible for ongoing compliance. **Date of Compliance:** 5/08/2015	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	**F425 483.60(a),(b) Pharmaceutical Services, Accurate Procedures,RPH** It is a requirement of this facility to provide routine emergency drugs to residents and procedures that assure accurate acquiring, receiving, dispensing, and administering of all drugs and biological to meet the needs of each resident. **How Corrective Action will be accomplished for residents affected:** Resident 17 has been discharged from the facility. All pain medications were on board and resident was able	

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	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 22 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that three of 22 residents (Resident 14, Resident 15, and Resident 17) received medications from the pharmacy in a manner timely enough to avoid missed doses of scheduled medications. 1. For Resident 15, the pharmacy failed to deliver oxycodone (a pain relieving medication) on 1/1/15, 1/2/15, 1/3/15, 1/10/15, 3/18/15, and 3/19/15 before doses were missed. This failure resulted in Resident 15 not receiving adequate pain medication, with the potential for withdrawal symptoms (a group of symptoms that occurs when some medications are abruptly discontinued or decreased in dosage) to occur. 2. For Resident 14, the pharmacy did not deliver Spiriva (an inhaled medication to improve respiratory function) before a dose was missed. This failure had the potential to result in breathing difficulty for Resident 14. 3. For Resident 17, the pharmacy did not deliver oral morphine (pain relieving medication) before one scheduled dose was missed, which resulted in inadequate pain relief for Resident 17. Findings: 1. A review of the clinical record for Resident 15 indicated he was admitted to the facility 7/8/14, with diagnoses that included chronic pain syndrome, infection of the brain, and hemiplegia (paralysis of one side of the body). The Minimum Data Set (MDS, a resident assessment tool used to guide care) dated 7/18/14, indicated Resident	F 425	to participate in therapy and be discharged home per plan. Resident 15 is currently receiving medications as ordered from the physician. MD has been notified of the need to sign written requests from the pharmacy for refills of medication. Resident 14 has been discharged from the facility with available medications to another SNF. **Identification of Residents with the Potential to be Affected:** All residents who have medication orders have the potential to be affected by this deficiency. Physician orders will be utilized to determine resident who have potential to be affected. 1. All medications for new admissions are now being processed by the ~~Hayward~~ Pharmacy rather than the Lodi location. Deliveries have been rerouted so that facility will receive orders early in the delivery run rather than last. 2. Charge Nurses will order medications from the pharmacy as soon as practical following the admission using Omnicare ordering procedures and will fax orders to the	5/8/15

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F 425	Continued From page 23 15 understood was what said to him, and was able to be understood, with a Brief Interview for Mental Status score of 10. (BIMS, an assessment tool for a resident's orientation to time, and capacity to remember. The BIMS range is from 0-15, with zero the most impaired. A score of 10 is an indication of moderate impairment.) Resident 15 required extensive assistance to get out of the bed or use a wheelchair. The MDS further indicated Resident 15 was on scheduled pain medication, but still had occasional pain at a level of eight on a scale of one to ten (with ten the worst pain). A review of the physician orders for Resident 15, dated January 2015, indicated a pain medication regimen of: ten milligrams (mg) of oral oxycodone was to be given every six hours around the clock; a transdermal (skin) patch that delivered 25 micrograms per hour of Fentanyl was to be changed every three days; and two mg of oral morphine sulfate could be given every four hours, if needed for pain. Nursing staff was to monitor and record Resident 15's level of pain every shift on the "Medication Administration Record (MAR), Pain Monitoring Scale." The MAR indicated a 0-10 scale was to be utilized: "0=none; 1-3=mild pain; 4-6=moderate pain; 7-9=severe pain; 10=worst pain." A review of the clinical record for Resident 15, the MAR, dated January 2015, indicated missed doses of oxycodone on: 1/1/15 at 6 a.m., 12 p.m., and 6 p.m.; 1/2/15 at 12 a/m., 6 a.m., and 12 p.m.; 1/3/15 at 12 p.m., 3 p.m.; 1/10/15 at 6 p.m. A review of the MAR dated March 2015, indicated missed doses of oxycodone on: 3/18/15 at 12 p.m., 6 p.m.; and 3/19/15 at 12 a.m., which caused a 24 hour gap in oxycodone administration. During a telephone interview on 4/3/15, at 9 a.m.,	F 425	pharmacy including any written scripts for controlled substances for dispensing. Refills will be ordered in a timely manner to ensure a continuous supply of medications is available. The following steps will be completed when a medication is not delivered in time for the required dosage time: a) Call the pharmacy to check on delivery time or use Omniview to verify that a script has been received and processed and scheduled for delivery. Inform the pharmacy of need for drug by next dose time. b) Using the e-kit as appropriate for meds available in the e-kit. c) Notify the Director of Nurses, that medication has not been received and to administer medication as ordered by the physician. d) If the medication cannot be delivered by the next dosage time, the nurse will notify the physician for further orders. e) DON will track any delivery issues using a QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 24	F 425		

the pharmacy compliance supervisor (PCS) stated the pharmacy required five days of prior notice before a renewed medication was needed, and that oxycodone required an authorization letter from the physician before the medication could be renewed or released from emergency stores (e-kit). The PCS confirmed that the facility sent a renewal request on 12/28/14, but stated the first fax was sent to the physician three days later, on 1/1/15 at 11:20 a.m. The PCS stated that the pharmacy responsibility in regards to refilling medication, was to notify the physician by fax of the need for a refill. The physician was contacted 1/1/15 at 2:55 p.m., after the nursing supervisor at the facility, Registered Nurse 2 (RN 2), informed the pharmacy that Resident 15 was out of oxycodone. The pharmacy received the physician authorization the next day, on 1/2/15, at 3:41 p.m. At 5:26 p.m., on 1/2/15, the pharmacy authorized release of six tablets of five milligram/tablet oxycodone from the emergency kit (e-kit) for Resident 15's use while delivery of the oxycodone was pending. The pharmacy arranged for delivery of the oxycodone on 1/3/15, in the transport leaving the pharmacy at 4 p.m. The PCS confirmed that the transportation time from the pharmacy to the facility could be as long as three to four hours. The PCS stated that only six tablets (three doses with two tablets per dose) were authorized to be used from the e-kit. The PCS was unable to provide any reason for why only 6 tablets were authorized, or how the time for delivery of the oxycodone was determined.

During a review of the clinical record of Resident 15, the "Progress Notes," dated 1/3/15, at 6:12 p.m., indicated, "Med is not available. Awaiting for pharmacy delivery." Physical delivery of the oxycodone occurred after 6 p.m., more than 24

Measures to Prevent Recurrence

1. Licensed Nurses have been re-educated regarding Medication Ordering and Processing on 3/16/15, 3/25/15, 3/27/15, 4/15/15, and 4/16/15 by the Regional Clinical Director, Director of Nursing and Omnicare Pharmacy Nurse.

2. Charge nurses will have primary responsibility for ensuring that all meds are available for administration and will notify the pharmacy and the DON prior to any missed doses.

The following steps will be completed when a medication is not delivered in time for the required dosage time.

a) Call the pharmacy to check on delivery time or use Omniview to verify that a script has been received and processed and scheduled for delivery. Inform the pharmacy of need for drug by next dose time.
b) Using the e-kit as appropriate for meds available in the e-kit
c) Notify the Director of Nurses, that medication has not been received and to administer medication as ordered by the physician.
d) If the medication cannot be delivered by the next dosage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 25	F 425		

hours after the physician authorization, and resulted in two additional missed doses on 1/3/15 (12 p.m. and 6 p.m.).

A review of the pharmacy list of the "Controlled Drug Emergency Kit," dated exp. 6/30/15, indicated presence of eight tablets of 5 mg oxycodone tablets in the e-kit.

A review of the pharmacy record, "Grid Notes," dated 1/1/2015, indicated the physician was contacted, and an authorization form was sent for the physician's signature on 1/1/15, at 2:58 p.m. The "Grid Notes," dated 1/2/15, at 9:34 a.m., indicated that the facility contacted the pharmacy for another copy of the authorization letter to be faxed, as the facility was still waiting for the oxycodone. The "Grid Notes," dated 1/4/15, at 9:58 a.m., indicated the oxycodone had been refilled on 1/3/15.
During a review of the clinical record for Resident 15, the Controlled Drug Record dated "received 12/27/14," indicated the last dose of oxycodone from the 12/27/14 delivery was given 1/1/15, at 12 a.m. The January 2015 MAR indicated no doses of oxycodone were given 1/1/15 at 6 a.m., 12 p.m., or 6 p.m.; 1/2/15 at 12 a/m., 6 a.m., or 12 p.m.; or 1/3/15 at 12 p.m., or 3 p.m. During a review of the clinical record for Resident 15, the Progress Notes dated 1/3/15 at 11:42 a.m., and 6:12 p.m. indicated, "Medication is not available. Awaiting pharmacy delivery."
During a review of the clinical record for Resident 15, the January 2015 MAR indicated Resident 15 received 11 oral doses of 2 mg morphine sulfate for pain from 1/1/15 to 1/4/15, during the time of missed oxycodone doses. The MAR further indicated a pain score of 5 (moderate pain) for five of the nine documented pain scores in this

time, the nurse will notify the physician for further orders.
e) DON will track any delivery issues using a QAPI tool.

3. DON and/or Nursing Supervisor will verify that all needed meds were delivered in Daily Stand Up and any delivery issues will be immediately corrected and tracked using the QAPI tool.

4. Omnicare will be asked to determine cause of delivery failure and report back to the facility which will also be tracked on the QAPI tool.

Monitoring Corrective Action and Responsibility:

1. Consultant Pharmacist will verify during the Monthly Regimen Review that all meds were delivered and available for administration and will reflect any issues in the monthly report.

2. DON will present findings of the QAPI tool at QA&A for review and recommendations.

3. Administrator with the QA&A Committee will have oversight of Pharmacy Services.

Date of compliance:
5/8/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 26	F 425		

time period.
During a review of the clinical record for Resident 15, the Controlled Drug Record dated "received 1/3/15," indicated the last dose from the 1/3/15 delivery of oxycodone was given 1/10/15, at 12 p.m. The January 2015 MAR indicated no oxycodone was given on 1/10/15, at 6 p.m.
During a review of the clinical record for Resident 15, the Nursing Progress Notes dated 1/10/15, at 5:37 p.m., indicated, "Med is not available, waiting for pharmacy delivery."
During a telephone interview on 4/3/15, at 9 a.m., the PCS stated the pharmacy received a refill request for the oxycodone for Resident 15 on 3/13/15. PCS stated the pharmacy faxed the authorization continuation letter to the physician on 3/14/15, 3/15/15, and 3/17/15. The authorization letter was returned to the pharmacy on 3/17/15, at 5:20 p.m. The renewal was processed on 3/18/15, at 6:36 a.m., with delivery arranged for the transport leaving the pharmacy on 3/19/15 at 1 a.m. The oxycodone was delivered to the facility on 3/19/15, at 2:47 a.m. The PCS was unable to provide rationale for why delivery of the oxycodone wasn't arranged for an earlier delivery time to the facility.
During a review of the clinical record for Resident 15, the Controlled Drug Record dated "received 3/5/15," indicated the last dose of oxycodone from the 3/5/15 delivery was given 3/18/15, at 6 a.m. The March 2015 MAR indicated no doses of oxycodone were given 3/18/15 at 12 p.m., 6 p.m., or 3/19/15 at 12 a.m. The time from authorization to first missed dose equaled 12 hours and 40 minutes, with 24 hours between administered doses of oxycodone. There was no authorization for use of oxycodone from the e-kit during the time period of these missed doses.
During an interview on 3/26/15, at 8:05 a.m.,

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	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 27	F 425		

Licensed Vocational Nurse 1 (LVN 1) stated she noticed Resident 15 had five days of oxycodone left on 3/13/15, so she spoke to the physician, called the pharmacy, and faxed the renewal request on 3/13/15. On 3/18/15, the medication had not been received, and the last available dose was given at 6 a.m. that morning. LVN 1 called the pharmacy on 3/18/15, at 7 a.m., and she was informed that delivery of the medication would be at 2 p.m. that day. Resident 15 missed the 12 p.m. dose of oxycodone, but when LVN 1 informed the physician of the situation, the physician told her the authorization had been signed, and the pharmacy would be delivering the oxycodone; he did not authorize use of the e-kit. LVN 1 gave Resident 15 a 2 mg dose of oral morphine at 10 a.m. on 3/18/15, and he did not complain of pain at noon, 2 p.m., or 3 p.m.

A review of the clinical record for Resident 15, "Progress Notes," dated 3/18/15, at 7:04 p.m., indicated, "Med not available, and 3/19/15 at 12:47 a.m., indicated, "Waiting for medication delivery."

During a review of the clinical record for Resident 15, the March 2015 MAR indicated Resident 15 received three oral doses of 2 mg morphine sulfate during the time of missed oxycodone doses from 3/18/15 to 3/19/15. The MAR further indicated a documented pain score of 6 (moderate pain) for the shift beginning at 11 p.m. on 3/18/15, and ending 7:30 a.m. on 3/19/15.

During a review of the clinical record of Resident 15, the "Progress Notes," dated 3/19/15, at 4:12 a.m., indicated a pain score of seven (severe pain).

During an observation and concurrent interview on 3/26/15, at 9:25 a.m., Resident 15 was lying in bed, with the head of the bed elevated, watching television. Resident 15 verbally responded to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 28	F 425		

questions, and although his speech was slightly garbled, he was understandable. He said it was painful when he missed doses of oxycodone the previous week [week of March 15-22]. Resident 15 said both his legs hurt, and he "felt bad." He stated he was given doses of morphine during the time of the missed oxycodone doses, but that they didn't really take away the pain. He said he had felt "that bad" one other time, sometime after Christmas, when he also didn't receive several doses of oxycodone. Resident 15 said it was hard to speak and took so much energy that he preferred for his Responsible Party (RP 1) to speak for him during extended conversations.
During an interview on 3/26/15, at 9:05 a.m., the RP 1 stated she visited daily and assisted with daily care needs (e.g., eating, repositioning, grooming). She stated that Resident 15 had missed doses of the oxycodone on March 18 and 19. When RP 1 visited on the morning of 3/19/15, Resident 15 said he didn't feel right overnight, and thought he might have been going through withdrawal. RP 1 said she had told staff he was in active withdrawal a couple months earlier, when doses of the oxycodone had been missed. She stated that on the earlier occasion of missed oxycodone he was very distressed. She said he had constant jitters, and kept grabbing the bed, saying, "Something's not right." She said he didn't look or act right, and she gave the example that he refused his favorite snack (a lollipop).
During an interview on 4/8/15 at 11 a.m., the Pharmacy Consultant 1 stated that pain medications should be delivered to the facility within four hours of a physician's order. The PC 1 stated he was unable to provide an explanation for the delayed delivery time for the oxycodone on 1/2/15 or 3/18/15, or the authorization of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 29	F 425		

insufficient doses from the e-kit on 1/2/15. The Pharmacy Consultant 2 (PC 2) was also present at the interview, and confirmed that timely medication delivery was first identified as an issue on 3/26/15, in regards to the 3/19/15, 1 a.m. delivery. PC 2 stated the medications were sent from the pharmacy at 1 a.m., and arrived at the facility at 2:47 a.m., resulting in delayed administration to some residents. PC 2 was unaware of any other delivery issues.

A review of Lexi-Comp (an on-line resource for healthcare professionals), "Oxycodone," accessed 4/6/15, indicated that oxycodone and morphine were classified as opiate agonists (a class of drugs that stimulate opiate receptors and effectively relieve pain without producing loss of consciousness), which are known to have the risk of physical dependence with continued administration over time. Lexi-Comp also indicated, "Current principles of pain management indicate that analgesics, including opiate agonists, preferably should be administered at regularly scheduled intervals for both the acute and chronic management of pain ..."
[http://online.lexi.com/lco/action/doc/retrieve/docid/complete_ashp/413380#ahflist]

A review of MedlinePlus (the National Institutes of Health's Web site), "Oxycodone," accessed 4/6/15, indicated, "Do not stop taking oxycodone without talking to your doctor. If you stop taking this medication suddenly, you may experience withdrawal symptoms such as restlessness, watery eyes, runny nose, sneezing, yawning, sweating, chills, muscle or joint aches or pains, weakness, irritability, anxiety, depression, difficulty falling asleep or staying asleep, cramps, nausea, vomiting, diarrhea, loss of appetite, fast heartbeat, and fast breathing. Your doctor will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 425	Continued From page 30	F 425		

probably decrease your dose gradually." http://www.nlm.nih.gov/medlineplus/ency/article/000949.htm

2. A review of the clinical record for Resident 14 indicated he was admitted on 1/10/15, with diagnoses that included chronic airway obstruction (a lung condition that causes difficulty with breathing), congestive heart failure, and high blood pressure.

A review of physician ' s orders dated 1/10/15 indicated Resident 14 was to receive the inhaled respiratory medication, Spiriva, once a day, for the chronic airway obstruction.

A review of the Medication Administration Record (MAR) for Resident 14, indicated Spiriva was not given 1/11/15 or 1/12/15. During an interview on 4/8/15, at 1:35 p.m., the Regional Clinical Director (RCD) stated Resident 14 received all ordered medications from the emergency kit (e-kit), except for Spiriva, which was not available from the e-kit.

A review of Resident 14's "Progress Notes" dated 1/11/15, indicated licensed nursing staff was waiting for delivery of the admission medications. A note dated 1/11/15, at 12:11 p.m., by Licensed Vocational Nurse 2 (LVN 2) indicated, "following Pharmacy for pending meds." A note dated 1/11/15, at 9:57 p.m., by Registered Nurse 1 (RN 1) indicated, " Med is not available. Waiting for pharmacy delivery." A note dated 1/12/15 at 10:11 a.m., by LVN 3 indicated, "Medication on process of delivery." A note dated 1/12/15, at 7:07 p.m., by LVN 5 indicated, "Called and followed up, awaiting meds delivery from pharmacy."

During a telephone interview on 4/3/15, at 10 a.m., the Pharmacy Compliance Supervisor (PCS) stated a face sheet (a form that includes resident data such as name, birthdate, diagnosis,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 425	Continued From page 31	F 425		

and payment source) had been received by the pharmacy on 1/11/15. PCS stated the face sheet was faxed back to the facility with a request for medication orders on 1/11/15, but that no fax was received until 1/12/15 at 12:21 a.m., when the medication orders were received by the pharmacy. PCS stated the Spiriva was delivered to the facility 1/12/15, at 8:47 p.m.

A review of a copy of a fax to the pharmacy titled, " New Admissions Only, " indicated a date of 1/12/15, Resident 14 ' s name, "page 4 of 4" and the note, "Please see attached orders and send ASAP." Copies of three pages of physician ' s admission orders for Resident 14 were attached to the fax copy, which included the order for inhaled Spiriva, once a day.

During an interview on 4/8/15, at 11:45 a.m., the Pharmacy Consultant 1 (PC 1) stated the pharmacy would not be concerned about receipt of a resident face sheet without accompanying admission orders, because sometimes pre-admitted residents would have admission delayed or cancelled.

A review of a copy of an e-mail to the Regional Clinical Director (RCD), from the Back End Manager (BEM) of the pharmacy, dated 3/26/15 at 1:04 p.m. (received from the RCD 3/26/15, at 3:30 p.m.), indicated, "Attached are the records regarding the Spiriva order ...We received Fax on 1/12/15 at 12:21 a.m. (21 minutes after midnight), delivered at 8:47 p.m ....I have also researched the fax's from the 10th through the 11th and there are no records of this residents admission orders." The pharmacy delivery of the Spiriva on 1/12/15 occurred 20 hours and 26 minutes after receipt of the medication orders.

A review of MedlinePlus, "Tiotropium [generic name of Spiriva]," (accessed 4/14/15) indicated, "Tiotropium is used to prevent wheezing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 32	F 425		

shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) .... Tiotropium controls COPD but does not cure it. It may take a few weeks before you feel the full benefits of tiotropium. Continue to take tiotropium even if you feel well. Do not stop taking tiotropium without talking to your doctor."
[http://www.nlm.nih.gov/medlineplus/druginfo/meds/a604018.html]
A review of the Pharmacy Consulting Agreement, effective date of July 1, 2010 through June 30, 2016, indicated, "1.b. Consultant will assist facility in providing timely and appropriate Pharmacy Products and Services that support residents' healthcare needs, that are consistent with current standards of practice, and that meet state and federal requirements ....1.c.vi. Strive to assure that medications are requested, received and administered in a timely manner as ordered by the authorized prescriber ..."

2. Clinical record review for Resident 17 on 3/24/15 at 8:30 a.m., indicated Resident 17 was admitted on 3/18/15 after left hip replacement surgery and had a history of bilateral (both) hips osteoarthritis (bone joints disease and swelling) and spinal stenosis (Spinal stenosis is the narrowing of spaces in the spine causing pressure on the spinal cord and nerves).

Admission order for Resident 17's pain management included Morphine Sulfate ER (Extended Release) (narcotic pain reliever)100 milligram tablet. Give 1 tablet by mouth every 8 hours for pain management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 33 Facility's every eight hour medication schedule was 6 a.m.; 2 p.m.; 10p.m. Review of Resident 17's admission record indicated that pain assessment was done on 3/18/15 at 11:38 p.m., several hours after admission. The assessment indicated that Resident 17 verbally described his pain intensity level was 7 , Resident 17 was in severe pain. LVN 6 (Licensed Vocational Nurse 6) who was assigned to take care of Resident 17 on 3/19/15 night shift, was interviewed on 3/ 26/15 at 9:26 a.m. she stated that the report and instructions given to her by the afternoon shift (3/18/15) licensed nurse was that Resident 17's Morphine tablets were not delivered by the pharmacy, Resident 17 missed his 10:00 p.m. dose. LVN 6 gave two Percocet tablets for Resident 17's pain at 1:30 a.m. on 3/19/15 . At that time according to LVN 6, Resident 17's pain level was 8 (severe pain) . During the interview LVN 6 stated that the Percocet tablets were ordered for "breakthrough pain" (refers to an episodic increase (flare-up) pain in someone whose pain is generally being managed by his/her current medication regimen). Resident 17's MAR (Medication Administration Record) dated 3/18/15 indicated that Resident 17's pain level was 8 (severe pain) during the afternoon 3/18/15 and 3/19/15 night shift. Morphine was not administered until 3/19/15 at 5:00 a.m. Resident 17's 10 p.m. Morphine dose was not given. On 3/ 26/15 at 9:35 a.m. during an interview Resident 17 described how "miserable" he was and in "so much pain and discomfort" that night . He further stated that he begged the nurses to	F 425	**F461 483.70(d)(1)(vi-(vii),(d)(2) Bedrooms-Window/Floor, Bed/Furniture Closet** It is the policy of this facility to provide individual closet space that is accessible to each resident. **How Corrective Action will be accomplished for residents affected:** Resident 17 has been discharged home from the facility. A dresser has been purchased that would have been available to the resident. **Identification of Residents with the Potential to be Affected:** Residents who cannot access closet storage in their rooms have the potential to be affected. Maintenance reviewed all current residents to determine if any other resident is affected by the location and availability of the closet.	

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	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 425	Continued From page 34	F 425	**Measures to Prevent Recurrence**:	
	call his doctor and "do something, they seem to not understand how bad these pains are." The only answer he got was that "they" did not "deliver" his Morphine. Instead he was given Percocet tablets . Resident 17 said that he was on "chronic pain" (persistent pain refers to a pain state that continues for a prolonged period of time or recurs more than intermittently for months or years) management at home and prior to his surgery. Resident 17 explained that a "break" and "missed" dose in Morphine schedule means he will be back to "zero" in his pain control schedule which made managing his pain very difficult. Percocet tablets should only be given in between his regular doses of Morphine. During the interview Resident 17 said that he found out from the nurses that Morphine was delivered at around 2 o'clock the morning after he was admitted but still "they" did not give it to him because the nurse told him that "it is not time yet", nurse waited to give the Morphine tablet at 5 o'clock in the morning. PC1 and PC2 , two Facility Pharmacy Consultants were interviewed on 4/8/15 at 11:05 a.m., both confirmed that Resident 17's Morphine ER was delivered on 3/19/15 at 2:57 a.m.		1. Rooms will be monitored during Quality Rounds to identify any residents who are having trouble accessing the closet. 2. Maintenance will be responsible for arranging for a solution. **Monitoring Corrective Action and Responsibility:** Administrator will monitor to ensure that resident solution is acceptable. **Date of compliance:** 5/08/2015 **F520 483.75 (o)(1) QAA Committee-Members/Meet Quarterly/Plans** It is this facility's policy to maintain a Quality Assurance Committee that meets at least quarterly to identify and correct quality issues with the development and implementation of action plans as necessary.	
F 461 SS=D	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress;	F 461	**How Corrective Action will be accomplished for residents affected:** Resident 17 has been discharged from the facility. All pain medications were on board and resident was able	

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	555398	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 461	Continued From page 35 (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview facility failed to provide an accesible and individual closet space for storage of personal clothings and belongings for one (Resident 17) of 22 sampled residents. Failure did not protect the residents belongings from getting lost and exposure to dirt. Findings: During the initial tour of the facility with CSC 1 (Central Supply Clerk 1) on 3/23/15 at 8:30 a.m. , Resident 17's luggage was observed on a chair, it was far from his reach and inaccessible to the resident. In an interview Resident 17 and resident's next of	F 461	to participate in therapy and be discharged home per plan. Resident 15 is currently receiving medications as ordered from the physician. MD has been notified of the need to sign written requests from the pharmacy for refills of medication. Resident 14 has been discharged from the facility with available medications to another SNF. **Identification of Residents with the Potential to be Affected:** All residents have the potential to be affected by the deficient practice. 1. All medications for new admissions are now being processed by the ~~Hayward~~ Pharmacy rather than the ~~Lodi~~ location. Delivery times have been revised to meet the needs of the facility. 2. Nurses have been re-educated on 3/16/15, 3/25/15, 3/27/15, 4/15/15, and 4/16/15 by the Regional Clinical Director, Director of Nursing and the Omnicare Pharmacy Nurse regarding the medication ordering process including how to order medication and steps to follow when a medication is not delivered in time for the required dosage time	

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F 461	Continued From page 36	F 461		
	kin, both stated that upon resident's admission to the facility, the staff put the luggage on the floor. Next of kin requested for a place where they can secure Resident 17's belongings and hang resident's clothes, the staff gave resident a chair to put his luggage up. The same luggage was observed situated in the chair for the entire survey (3/23/15 through 3/26/15). An interview with the facility's MS (Maintenance Supervisor) on 3/26/15 he stated that there was a closet designated for the two residents in the room. Upon observation, Resident 17 and the next of kin will have difficult access to the designated closet . A wheelchair, bedside table and night stand were blocking the closet not accessible to Resident 17 as well as to his next of kin. The closet condition was made known to the facility's MS, he stated that he will bring it to the facility's management for discussion.		including calling the pharmacy, using Omniview to verify that a script has been received and processed, and notifying the Director of Nurses, and using the e-kit as appropriate to administer medication as ordered by the physician. If the medication cannot be delivered by the next dosage time, the nurse will notify the physician for further orders. 3. DON and/ or Nursing Supervisor will verify that all meds have been delivered and administered in a timely manner daily as a part of the Daily Stand Up Meeting. 4. If any medication is not received or administered as required, the pharmacy will be asked to research the missing medication and do root cause analysis, and make corrective action as required. The following steps will be completed when a medication is not delivered in time for the required dosage time: f) Call the pharmacy to check on delivery time or use Omniview to verify that a script has been received and processed and scheduled for delivery. Inform the pharmacy of need for drug by next dose time.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 520	Continued From page 37 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to identify the issue that medications were not delivered timely for 3 of 22 sampled residents (17, 15, 14) to the Quality Assessment and Assurance Committee resulting in the lack of a plan to improve medication delivery. 1. For Resident 17's chronic pain, the facility failed to ensure that they had the pain medication (Morphine ER 100 milligrams[mg.] orally) as ordered for Resident 17's pain and failed to notify the resident's physician when Morphine was not available resulting in Resident 17 experiencing unrelieved pain. 2. For Resident 15, the facility failed to provide scheduled pain medication (Oxycodone , a narcotic pain reliever) on eleven occasions, that resulted in inadequate pain control and discomfort from symptoms due to not getting the medication. 3. For Resident 14 the facility failed to missed two doses of Spiriva due to This failure resulted in	F 520	g) Using the e-kit as appropriate for meds available in the e-kit h) Notify the Director of Nurses, that medication has not been received and to administer medication as ordered by the physician. i) If the medication cannot be delivered by the next dosage time, the nurse will notify the physician for further orders. j) DON will track any delivery issues using a QAPI **Measures to Prevent Recurrence** DON and/or Nursing Supervisor will verify that all needed meds were delivered in Daily Stand Up and any delivery issues will be immediately corrected and tracked using the QAPI tool. DON will present findings of the QAPI tool at QA&A for review and recommendations. ~~Omnicare~~ will be asked to determine cause of delivery failure and report back to the facility which will also be tracked on the QAPI tool. The Pharmacist will present findings to the QA&A committee for review and development of an action plan as necessary.	

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	555398	A. BUILDING _____ B. WING _____	04/08/2015

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F 520	Continued From page 38 two days of missed administration (two doses) of a respiratory medication (Spiriva), which had the potential to cause difficulty breathing for Resident 14. Findings : By interview with the Administrator the QAA Committee did not identify as QA project the following concerns: 1. The lack of Morphine for Resident 17's chronic pain, the lack of Oxycodone for Resident 15 and Spiriva not being ordered timely for Resident 14. During a telephone interview on 4/8/15, at 10:35 a.m., the Medical Director (PHYSICIAN 2), stated he was not aware of any issues with pharmacy deliveries, except after initiation of new Drug Enforcement Administration rules a few months ago. He said there were short delays of an hour or so at that time, but no issues since. He stated that he did not handle pharmacy delivery issues; the Director of Nursing dealt with those problems. He stated that he was not aware that the pharmacy had ever had issues with obtaining physician authorization.	F 520	Administrator with the QA&A Committee will have oversight of Pharmacy Service. **Monitoring Corrective Action and Responsibility:** The Administrator will be responsible for ongoing compliance. **Date of compliance:** 5/08/2015	5/8