STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED PER IDR The following reflects the findings of the California Department of Public Health during an annual recertification survey, conducted from 2/8/16 through 2/11/16. The census at the time of the survey was 91, with no bed holds. The total sample size was 19. Complaint # CA00475156 was incorporated into the survey. There were no deficiencies related to this complaint. Representing the Department were Health Facilities Evaluator Nurses 34735, 33922, 36588, and Health Facilities Evaluator Supervisor 29509. Glossary of Terms: LN Licensed Nurse CNA Certified Nursing Assistant DON Director of Nursing DSD Director of Staff Development IV Intravenous EMAR Electronic Medication Administration Record ADM Administrator DS Dietary Supervisor MS Maintenance Staff RD Registered Dietician	F 000	***Preparation and/or execution of this Plan of Correction (POC) does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following POC which shall constitute Poway Healthcare Center's credible allegation of compliance by March 10, 2016.*** RECEIVED CA DEPT OF PUBLIC HEALTH MAR 25 2016 LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	**F279** Resident 19 was discharged from the facility on 02.20.16.	03.10.16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 03/09/2016

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.

Accepted 3/28/16 M. Mudron

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 279	Continued From page 1 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a plan of care was developed related to a midline catheter (a hollow tube inserted through the upper arm into a larger vein) for 1 of 19 sampled residents (19). As a result, the LNs were inconsistent in measuring the catheter's external length and Resident 19 was at risk for potential complications related to her midline catheter. Findings: Resident 19 was admitted to the facility on 2/5/16 with diagnoses which included a ruptured appendix, according to the History and Physical. During a joint interview and clinical record review	F 279	No current residents with a midline catheter in place, but residents on intravenous (IV) therapy have been reviewed for development of an IV care plan. All Registered Nurses have been in-serviced as of 03.02.16 regarding the IV therapy policy and developing an IV plan of care by the DSD/DON. Admission audits will be conducted by Medical Records Staff of patients admitted with IV access devices for baseline charted assessment of arm circumference and external catheter length within patients IV Care plans. Those identified without information will be given to the DON/or Designee to provide comprehensive assessment or ensure information is documented into the patients care plan and clinical record. Medical records will conduct ongoing audits weekly for completion of the arm and external length measurements within the IV treatment record for compliance for one month and then monthly for 5 months. Any licensed nurse identified as not documenting the required assessment component and/or developing an IV care plan will be in-serviced and counseled by the DON/designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 279	Continued From page 2 on 2/10/16, LN 11 stated Resident 19 was admitted to the facility with a midline catheter for IV antibiotics. LN 11 stated, it was important to measure the external length of the catheter during dressing changes to assure the catheter had not moved from where it was placed. LN 11 stated, she measured the external length of the catheter by using a measuring tape. LN 11 confirmed there was no plan of care in Resident 19's record indicating how to measure the external length of the catheter and no documented measurements. During a joint interview and clinical record review on 2/11/16 at 11 A.M., LN 13 stated, it was important to measure the external length of Resident 19's catheter during dressing changes. LN 13 stated, she measured the catheter length by the number on the catheter lumen at the insertion site. LN 13 confirmed there was no plan of care in the resident's record indicating how to measure the external length of the catheter and LN 13 was unable to locate the documented measurements. According to the facility's policy entitled, Care Plans, revised April 2011, "...care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and are resident oriented... are measurable...meet the resident's needs in accordance with the comprehensive assessment..."	F 279	The Medical Record staff will monitor for overall compliance and report the results and any trends from the audits to the monthly Quality Assurance Committee Meeting.	
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.	F 281	**F281** 1a. Resident 91 was re-assessed regarding his intravenous (IV) access, IV orders obtained and IV care plan developed.	03.10.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 281	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure LNs assessed and maintained PICC (a hollow tube inserted through the upper arm into a large vein near the heart) and midline (shorter than a PICC, extending through the arm to a larger vein) catheters in accordance with current standards of practice for 3 of 19 sampled residents (7, 19, and 91). As a result, Residents 7, 19 and 91 were at risk for potential complications from PICC or midline catheters. Findings: 1. Resident 91 was admitted to the facility on 10/24/15 with diagnoses which included urinary tract infection, according to the History and Physical dated 10/31/15. During a joint interview and clinical record review on 2/10/16, LN 11 stated Resident 91 had a PICC line placed for hydration. LN 11 stated, it was important to measure the external length of the catheter during dressing changes to assure the catheter had not dislodged (moved from where it was initially placed). LN 11 stated, she used a measuring tape to measure the catheter from the insertion site to the end of the catheter. LN 11 stated, she did not measure the circumference of the resident's arm above the catheter insertion site with every dressing change. LN 11 confirmed there was no documentation in Resident 91's clinical record which indicated the external length of the catheter when it was initially	F 281	2a. Resident 19 was discharged from the facility on 02.20.16. 3a. Resident 7's IV access was discontinued on 02.08.16. 1-3b. Residents on intravenous (IV) therapy have been reviewed for assessments according to the IV policy and the development of an IV care plan. All Registered Nurses have been in-serviced as of 03.02.16 regarding the IV therapy policy and developing an IV plan of care by the DSD/DON. 1-3c. Admission audits will be conducted by Medical Records of patients admitted with IV access devices for baseline charted assessment and orders of arm circumference and external catheter length within patients IV Care plans. Those identified without information will be given to the DON/or Designee to provide comprehensive assessment or ensure information is documented into the patients care plan and clinical record. Medical records will conduct ongoing audits weekly for completion of the arm and external length measurements within the IV treatment record for compliance for one month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 281	Continued From page 4 placed. LN 11 further confirmed there was no documentation in the record which indicated the external length of the catheter or the arm circumference during weekly dressing changes. LN 11 stated, she was unaware if the catheter had become dislodged or if the resident's arm circumference had grown. During an interview on 2/11/16 at 11 A.M., LN 13 stated, she measured the external length of the PICC by the number printed on the catheter closest to the insertion site. LN 13 stated, she did not measure the resident's arm circumference during dressing changes. 2. Resident 19 was admitted to the facility on 2/5/16 with diagnoses which included a ruptured appendix, according to the History and Physical. During an interview and clinical record review on 2/11/16 at 2:05 P.M., LN 14 stated it was important to assess the external length of Resident 19's midline catheter to assure the catheter had not become dislodged. LN 14 confirmed there was no documentation in Resident 91's record indicating the measurement of the external length of the catheter when it was placed. LN 14 stated, she should have called the hospital to get a baseline length of the catheter. LN 14 stated she changed the catheter dressing on 2/8/16 and was unaware if the catheter had dislodged. LN 14 further stated, she did not document the external length of the catheter when she changed the dressing. 3. Resident 7 was admitted to the facility on 1/29/16 with diagnoses which included recurrent UTI, according to the History and Physical dated, 2/1/16.	F 281	and then monthly for 5 months. Any licensed nurse identified as not obtaining IV orders and documenting the required assessment component and/or developing an IV care plan will be in-serviced and counseled by the DON/designee. 1-3d. The Medical Record staff will monitor for overall compliance and report the results and any trends from the audits to the monthly Quality Assurance Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 281	Continued From page 5 During an interview and clinical record review on 2/11/16 at 2:05 P.M., LN 14 stated she changed Resident 7's PICC dressing on 2/3/16. LN 14 confirmed there was no documentation in Resident 7's record indicating the external length of the catheter when it was placed and she was unaware if the catheter had become dislodged. LN 14 further stated, she did not document the external length of the catheter or the resident's arm circumference when she changed the dressing. During an interview on 2/10/16 at 2:50 P.M., the DON stated the LNs should have contacted the facility that placed Resident 7, 19, and 91's catheters to obtain the external length of the catheter. The DON further stated, the LNs should measure the external length of the catheter by documenting the number marked on the catheter at the insertion site in the residents' clinical record. During an interview on 2/11/16 at 2:20 P.M., the DSD stated, the LNs should have measured the external length of the catheter by using a measuring tape and documented the length in the residents' clinical record. The facility could not provide a policy and procedure related to the measurement of the external length of PICC or midline catheters and upper arm circumference during dressing changes. According to Berman, Snyder, Kozier, & Erb (2008) Kozier & Erb's Fundamentals of Nursing; Concepts, Process and Practice. Upper Saddle River, NJ: Pearson Education, Inc, "... measure	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 281	Continued From page 6 the patient's upper arm circumference... this serves as a reference point to determine with later measurements of the presence of swelling... measure and document the external portion of the catheter from the insertion site to the hub of the access cap... compare to the previously documented length to detect catheter dislodgement..."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow denture care orders for 1 of 19 sampled residents (15). As a result, Resident 15's dentures were lost. Findings: Resident 15 was readmitted to the facility on 3/3/15, with diagnoses which included Vascular Dementia, per the Admission Record. During an interview with Resident 15 on 2/8/16 at 2:50 P.M., Resident 15 stated she wrapped her dentures in paper, because she couldn't find her denture cup and then the dentures were accidentally thrown away. A record review of Resident 15's clinical record	F 282	**F282** Resident 15 was re-assessed and physician orders and the plan of care related to denture care was discontinued. Residents with dentures were reviewed and their orders and care plans were revised and/or discontinued as needed. Nursing and Social Services Staff were in-serviced on 03.09.16 regarding orders for denture care and the facility theft/loss policy by the DSD . Social Services Staff will conduct review of 5 random residents with dentures to ensure proper documentation and that their dentures have not been lost weekly for a month and then monthly	03.10.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 282	Continued From page 7 was completed on 2/9/16. According to Resident 15's Dental Care Plan, dated 3/3/15, "Resident has a history of misplacing her dentures. Resident has a history of placing dentures in napkin/tissue/clothes and food tray ...Goal Resident will not misplace dentures and use denture cup as instructed ...Approach Denture cup will be provided at bedside for her to place her dentures in prior to sleep." The following orders dated 7/30/15, "LN to give Resident upper dentures before breakfast ....LN to put upper dentures in med cart at bedtime ...LN to ensure Resident upper dentures are in room after each meal ... " According to a Registered Dietician Progress Note, dated 9/11/15, RD 1 noted, "...Has upper and lower dentures that fit well..." According to a Social Service Progress Note, dated 12/13/15, "SW met with resident's daughter...Dental: Facility has replaced upper denture recently and continues to use both upper and lower dentures ..." On 2/9/16 at 10:06 A.M., an interview was conducted with SSD 1. SSD 1 stated, she completed a Loss Investigation Report on 12/30/15, in which, she reported Resident 15 lost upper dentures on 12/29/15. On 2/9/16, a review of the EMAR History for the order, "LN to ensure Resident Upper Dentures are in room after each meal.", was documented as:	F 282	for the next 5 months. Any staff identified as not documenting dentures use and/or not reporting the loss of dentures will be in-serviced and counseled by the Social Services Director. The Social Services Director will monitor for overall compliance and report the results and any trends from the audits to the monthly Quality Assurance Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 282	Continued From page 8 - "12/22/15 13:55...Other comment: missing dentures" - "12/23/15 10:21...Other comment: missing dentures" - "12/28/15 13:24...Other Comment: missing dentures" - "12/28/15 13:24...Other Comment: missing dentures" - "12/29/15 13:24...Other Comment: missing dentures" - "12/29/15 19:24...Other Comment: missing dentures" An interview was conducted with LN 13 on 2/10/16 at 1:51 P.M. LN 13 stated, she noticed Resident 15 was not wearing her dentures at lunchtime on 12/29/15, and reported it to SSD 1. LN 13 said she was not aware of any reports that the resident's dentures were missing prior to 12/29/15. An interview was conducted with the DON 1 on 2/11/16 at 12 P.M. She stated she expected her nurses to ensure dentures were placed, removed and documented according to Resident 15's care plan and orders. She acknowledged that as of 2/11/16, Resident 15's upper and lower dentures were missing and had not been replaced. According to the facility's Policy and Procedure, Dentures, Cleaning and Storing, revised October 2010, "The purpose of this procedure are to protect the resident ' s dentures from breakage when dentures are out of the resident's mouth, and to store dentures at bedtime ...review the resident's care plan to assess for any special needs of the resident ...the following information should be recorded in the residents medical record ...The date and time the denture care was	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 282	Continued From page 9 performed ...Damaged, broken, ill-fitting, or lost dentures. The certified nursing assistant should report to the licensed nurse or social services ..."	F 282		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.40%. A total of 2 medication errors were observed within a sample size of 27 opportunities for error. As a result, Resident 75 was administered a medication not according to the physician's order and one medication was not administered as ordered. Findings: 1. On 2/9/16 at 10 A.M., LN 13 prepared Resident 75's morning medications for administration which included Nitro-Bid ointment. LN 13 applied a new dose of Nitro-Bid ointment to right chest and then wiped off the previous dose from left chest. On 2/9/16 at 3:10 P.M., Resident 75's Medication Reconciliation (a list of all medications a resident is taking) form was reviewed. The physician ordered, "Nitro-Bid 2% ointment, 1" topical.	F 332	**F332** LN 13 was coached and counseled by the DSD/DON 02.10.16. He is scheduled for a Med Pass Review with the Pharmacy Consultant on 03.10.16. All Licensed Staff have been In-serviced on the medication administration process, administering medications as ordered by the physician and the importance of proper e-MAR (electronic medication administration record) documentation by the DSD/DON 03.02.16. DSD/Designee will conduct weekly audits of (2) random license nurses for compliance with the med pass procedure for the next month and then monthly for the next 5 months. Any licensed nurse identified as administering medication error rate >5% will have pharmacy policy review of procedure compliance and will be coached and counseled by the DSD.	03.10.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 332	Continued From page 10 Apply to chest wall, wipe off previous dose before applying new dose." On 2/9/16 at 3:30 P.M., an interview was conducted with LN 13. The Nitro-Bid order for Resident 75 was reviewed. LN 13 stated he should have wiped off the previous dose before he applied the new dose. 2. During the same medication reconciliation review for Resident 75, according to a physician's order, dated 4/9/15, "OcuSoft Lid Scrub (eyelid cleanser... both eyelids - topical... Special Instructions (wipe both eyelids for blepharitis [a swelling of the eyelid that affects the eyelashes or tear production]) once a morning at 9:00 A.M." OcuSoft Lid Scrub was not included during the medication pass on 2/9/16 at 10 A.M. for Resident 75. However, during the medication reconcilitaion LN 13 documented it was given as a late administration. An interview was conducted with LN 13 on 2/9/16 at 3:30 P.M., LN 13 stated he did not administer OcuSoft Lid Scrub as ordered because the medication was not available and corrected the administration of the medication to "Not given-medication unavailable." According to the facility's Policy and Procedure, titled, Administering Medications, revised April 2010, "...Medications shall be administered in a safe and timely manner, and as prescribed..."	F 332	Any new nursing staff hired will be trained by the DSD/DON and then competency review by DSD or Pharmacy Consultant regarding medication administration process, administering medications as ordered by the physician and the importance of proper e-MAR documentation. The DSD will monitor for overall compliance and report the results and any trends from the audits to the monthly Quality Assurance Committee Meeting.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431	**F431** 1. The expired Glucerna was immediately discarded from the Central Supply Storage.	03.10.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 431	Continued From page 11 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to: 1. Ensure expired Glucerna 1.2 (nutritional	F 431	The Central Supply Storage area was reviewed for any other expired items and none was found. The Central Supply Staff and Nursing Staff was in-serviced on the facility policy for Storage of Medications on 03.02.16 by the DSD/DON. Weekly review of the Central Supply Storage area will be conducted for one month and then monthly for 6 months. Any expired items will be immediately removed. The Central Supply Staff will monitor for overall compliance and report results and any trends from the audits to the monthly Quality Assurance Committee Meeting. 2. LN 13 was coached and counseled by the DSD/DON February 2016. He is scheduled for a Med Pass Review with the Pharmacy Consultant on March 10, 2016. All Licensed Staff have been in-serviced on the medication administration process, administering medications as ordered by the physician, the importance of proper e-MAR (electronic medication administration record) documentation and not leaving medications unsecured by the DSD/DON 03.09.16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 431	Continued From page 12 medication supplement) was not available for resident use in 1 of 1 Central Supply Rooms. 2. Ensure the security of medications when left unattended at the bedside for one unsampled resident (75) and, As a result, this had the potential for residents to receive expired nutritional medications and for medications to be misplaced or misused. Findings: 1. An environmental tour was conducted on 2/10/16 at 2:30 P.M. During an inspection of the Central Supply Room with MS 1, 46 cans of Glucerna 1.2 were observed on a shelf. The cans were labeled with a use by date of 12/1/15 (expiration). MS 1 acknowledged the cans of Glucerna 1.2 were past the use by date and should have been removed from the Central Supply Room. On 2/10/16 at 4:20 P.M., an interview was conducted with DS 1. DS 1 said the Glucerna 1.2 should have been discarded or removed from Central Supply Room. During an interview with the DON 1 on 2/10/16 at 4:30 P.M., she stated, Glucerna 1.2 is considered a medication and should not have been stored in Central Supply Room past the use by date and accessible for nursing staff to administer to residents. According to the facility's Policy and Procedure, Revised April 2007, titled, Storage of Medications, "...The facility shall not use discontinued,	F 431	DSD/Designee will conduct weekly audits of (2) random license nurses medication handling procedure for the next month and then monthly for the next 5 months. Any licensed nurse identified as leaving medications at bedside will be in-serviced and counseled by the DSD. The DSD will monitor for overall compliance and report the results and any trends from the audits to the monthly Quality Assurance Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 431	Continued From page 13 outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed ..." 2. On 2/9/16 at 10 A.M., LN 13 entered Residents 74 and 75's room with a total of 10 medications to be administered to Resident 75. LN 13 placed the medication tray on Resident 75's bedside table located near the window. LN 13 left the medications on the bedside table to wash his hands in the residents' bathroom out of sight from the medication. LN 13 then left residents' room to return to the medication cart, located two doors down, before he returned to the room and administered Resident 75's oral medications. After LN 13 administered Resident 75's oral medications, he left eye drops and a topical medication on the bedside table and washed his hands in the residents' bathroom. LN 13 then returned to Resident 75's bedside and administered the remaining medications. LN 13 was interviewed on 2/10/16 at 0815. LN 13 stated he was "really nervous" during the Medication Pass Observation on 2/9/16. He further stated, he learned from that experience and understood about the Nitro paste and not to leave medications unattended. LN 13 was interviewed on 2/10/16 at 8:15 A.M. LN 13 stated he was "really nervous" during the Medication Pass Observation on 2/9/16. He further stated, he learned from that experience and understood about the Nitro paste and not to	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 431	Continued From page 14 leave medications unattended. According to the facility's Policy and Procedure, titled, Security of Medication, revised April 2008, "...Medications will be secured and under the supervision of the licensed nurse at all times. Medications will not be left unattended or left at the bedside..."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F441** 1 & 4ab. Facility Staff will be re-educated/ in- serviced on food handling of resident food requirements, resident food areas and the no co-mingling of staff food with patient food in locations of refrigerator designated for residents by the DSD 03.09.16. 2-3ab. Nursing Staff will be in-serviced by the DSD on infection control procedures to include highlighted areas of glucose meter cleaning, and disinfecting resident equipment before and after use by 03.09.16. 1 & 4c. The Food Service Supervisor or Registered Dietician will conduct a weekly meal time observations of food service and assistance by staff to ensure food is handled facility per policy for the next 3 months. Any staff identified as not following the facility procedure will be in-serviced and counseled by the DSD.	03.10.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 441	Continued From page 15 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: 4. On 2/10/16 at 11:30 A.M., a refrigerator, (18 3/4 inches x 17 inches x 19 1/4 inches), was located in Nurse Station 1. On the door of the refrigerator was a sign which read, "Resident Refrigerator". The refrigerator was opened with the MDS coordinator and she confirmed the contents inside the refrigerator as two unopened 4-ounce cartons of whole milk; one unlabeled 8 ounce can of liquid supplement, one 8-ounce bowl labeled "Applesauce 2/10/16" and one opened 8 ounce clear plastic bottle, half consumed labeled with a name. The MDS coordinator stated, the refrigerator was for resident use only. On 2/10/16 at 11:50 A.M., the MDS coordinator confirmed the clear plastic bottle belonged to a certified nurse assistant from the night shift. She further stated, the plastic bottle should not have been in the residents refrigerator, "It for residents only." According to the facility's policy and procedure dated June 2014, entitled Resident Refrigerators, "All food in the refrigerator will be labeled with the	F 441	2-3c. DSD/Designee will conduct weekly audits of (2) random license nurses med pass for compliance the infection control aspect of observing Licensed Nurses for disinfecting the glucometer and resident equipment cleaning per facility policy for the next month and then monthly for the next 5 months. Any staff identified as not following the facility procedures will be in-serviced and counseled by the DSD. 1 & 4d. The Food Service Supervisor or Registered Dietician's monitoring for compliance, results and trends from the observations will be reported to the monthly Quality Assurance Committee Meeting by the DSD for the next 3 months. 2-3d. DSD/Designee will report the monitoring for compliance, results and trends from the observations will be reported to the monthly Quality Assurance Committee Meeting by the DSD for the next 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 441	Continued From page 16 common name and open date." Based on observation and interview, the facility failed to ensure appropriate infection control techniques and practices were used when: 1. A CNA failed to use gloves or silverware when she prepared food in the dining room for 1 unsampled Resident (22), 2. The Licensed Nurses failed to disinfect a blood pressure cuff for one unsampled resident (47), after resident use; 3. The Licensed nurse failed to disinfect 2 of 4 glucometers (a monitor used for testing blood sugar in diabetics) after use and prior to returning them to the medication cart for the next use; and 4. A nursing staff member co-mingled her personal water bottle in 1 of 2 resident refrigerators. As a result, the residents were at risk for food borne illness. In addition, the failure to demonstrate the proper disinfection of resident-care devices had the potential for cross contamination (transmission of bacteria and viruses from resident to resident). Findings: 1. During a meal observation in the facility's main dining room on 2/8/15 at 12:25 P.M., CNA 11 was observed passing trays to the residents seated at the dining tables. CNA 11 removed Resident 22's tray from the tray cart, placed his plate and drinks	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 441	Continued From page 17	F 441		

in front of him. CNA 11 then picked up Resident 22's cornbread with ungloved hands, broke it in pieces, and buttered it. CNA 11 then walked back to the tray cart to remove another tray.

During an interview on 2/8/16 at 12:45 P.M., CNA 11 stated she used her bare hands to butter the resident's cornbread. CNA 11 stated, "I should have used a fork and knife; I shouldn't have used my hands without gloves."

During an interview on 2/11/16 at 4:30 P.M., the DON confirmed she observed CNA 11 use her bare hands to butter Resident 22's corn bread. The DON further stated, the CNA should have used a fork and knife to prepare the resident's food and not her bare hands.

2. On 2/9/16 at 9:15 A.M., the medication pass observation was conducted with LN 10.
LN 10 obtained a blood pressure cuff and stethoscope from bottom left drawer of the medication cart located outside Resident 47's room. LN 10 used an alcohol prep pad to disinfect the stethoscope, then entered Resident 47's room and obtained blood pressure and heartrate. She returned to the medication cart and placed the blood pressure cuff back into bottom left drawer without disinfecting the cuff and stethoscope.

3. On 2/10/16 at 7:03 A.M., LN 11 conducted the testing of the Glucometer and demonstrated how to record results in the log. LN 11 did not disinfect the glucometer before and after testing prior to returning the device to the medication cart.

On 2/10/16 at 7:12 A.M., LN 12 conducted the testing of the glucometer. LN 12 obtained the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 441	Continued From page 18 glucometer from the medication cart and disinfected the glucometer with a Sani Cloth Bleach wipe. LN 12 stated, he "Would dry glucometer with tissue so it is dry." LN 12 wiped the glucometer dry with a tissue. At 7:55 A.M., LN 12 obtained another glucometer from the medication cart and conducted testing. LN 12 wiped glucometer with Sani Cloth Bleach wipe and stated he would, "Wait ten minutes for bleach to dry so there were no germs on it." Reviewed the facility's Glucometer In-Service, dated 4/21/15, for Licensed Nurses. The LNs are to clean and disinfect glucometers after testing per the glucometer manufacturer. "According to the Centers for Disease Control and Prevention, cleaning and disinfecting of meters between resident use can prevent the transmission of viruses through indirect contact." According to Sani-Cloth Bleach Germicidal Disposable Wipe manufacturer's guidelines, "...wipes have an overall contact time of 4 minutes...the overall contact time is the time it takes the product to disinfect all the microorganisms (bacteria, virus or fungus) on the disinfectant's master label."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	**F514** Resident 89 was reassessed for pain management and a physician order to monitor her pain level every shift was obtained.	03.10.16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 514	Continued From page 19 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Licensed Nurses documented pain assessments in the clinical record for 1 of 19 sampled residents (89). As a result, Resident 89's record did not indicate the level of pain experienced by the resident. Findings: Resident 89 was admitted to the facility on 3/10/11 and started on hospice care (comfort care for end of life) for end stage dementia on 1/27/15, according to the History and Physical. During a joint interview and clinical record review on 2/10/16 at 9 A.M., LN 11 confirmed there was no pain assessment documented on Resident 89's EMAR from 2/1/16-2/9/16. LN 11 stated, Resident 89's pain level should be assessed each shift and documented on the EMAR. During an interview on 2/10/16 at 2:14 P.M., LN 12 stated, he did not document pain assessments for Resident 89 on 2/8/16. According to the facility's policy and procedure, titled, Pain Assessment and Management, dated April 2009, "... Upon completion of the pain assessment, the person conducting the	F 514	All residents of the facility were reviewed to ensure their clinical record included the pain monitoring is in place by 03.07.16. Nursing and Medical Records Staff was in-serviced on pain monitoring policy and documentation on 03.09.16. Medical Records Staff will conduct post admission review of new residents to ensure pain monitoring is in place. Those identified without pain monitoring will be given to DON/or Designee to ensure order is placed. Medical Records Staff will conduct a random review of 5 clinical records for pain monitoring documentation weekly and then monthly for the next 5 months. The Medical Record Staff will monitor for overall compliance and report the results and any trends from the audit to the monthly Quality Assurance Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 514	Continued From page 20 assessment shall record the information obtained from the assessment in the resident's medical record..."	F 514		