STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555579	A. BUILDING _____ B. WING _____	03/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARARAT NURSING FACILITY	15099 MISSION HILLS ROAD MISSION HILLS, CA 91345

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Licensing and Recertification Survey. Representing the Department of Public Health: [redacted], RN, HFEN [redacted], REHS, HFE [redacted] RN, HFEN Total Population: 180 Sample Size: 27	F 000	2012 APR -5 AM 3:24 OSHPD DIVISION OF FACILITIES LOS ANGELES COUNTY	
F 252 SS=B	Highest S/S= D 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a home like environment by not having a door to Rooms 15 and 16. Findings: On March 13, 2012, at 7:45 a.m., it was noted that Rooms 15 and 16 were observed without doors. During an interview with the facility's administrator, she stated that the two rooms	F 252	OSHPD Official will be on site on 4/5/12. His recommendation will be implemented and submitted to DPHS. All admissions in rooms 115 & 116 will be informed about the doors.	04/06/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary F. Dabika, RN, MS	Executive Director	4/5/12

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

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F 252	Continued From page 1 never had doors and were approved as is. She stated the resident in those rooms were provided privacy with privacy curtains. However, the rooms did not have doors like the rest of the rooms in the facility.	F 252		
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 follow the physician's order to be notified when the resident's blood sugar becomes less than 70 milligrams/deciliter (mg/dl) and to provide the resident with nursing interventions when blood sugar drops to 70 mg/dl, for one out of 27 sample resident (4). Findings: According to the admission record, Resident 4 was originally admitted to the facility on September 7, 2010, and readmitted on June 9, 2011, with diagnoses that included insulin dependant diabetes mellitus and hypertension. The resident had a physician's order dated February 9, 2011, to check the blood sugar (BS) by a finger stick and to administer sliding scale Novolog Insulin subcutaneously (SQ) before breakfast for the following parameters: BS 121 - 150 = 2 units. BS 151 - 200 = 4 units.	F 281	Resident #4 and all diabetic residents were identified. MD orders were recapped, implemented and documented. All RNs/LVNs were in-serviced to recap orders accurately and notify MD when blood sugar is less than 70mg/dl and document interventions including orange juice on MAR. Director of Clinical Services will monitor MD orders, blood sugar results and interventions of all diabetic residents and report findings to QI Committee quarterly. Compliance threshold – 100%	04/06/12

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F 281	Continued From page 2 BS 201 - 250= 6 units. BS 251 - 300= 8 units. BS 301 - 350= 10 units. BS 351 - 400= 12 units. The order also indicated to notify the physician for blood sugar over 400 mg/dl and less than 70 mg/dl. On March 15, 2012, at 2:30 p.m. a review of the medication administration record indicated the following: 1. On February 29, 2012, the resident's BS was 60 mg/dl at 7 a.m. 2. On January 18, 2012, the resident's BS was 64 mg / dl. 3. On December 28, 2011, the resident's BS was 63 mg/dl. There was no documentation that indicated the physician was notified. In addition, the licensed staff did not provide nursing intervention when the resident's blood sugar drops in order to prevent complications associated to low blood sugar. On March 15, 2012, at 3 p.m., during an interview with the Licensed Vocational Nurse (LVN) 1, and a review of the resident's physician's order dated March 2012, February 2012 and December 2011, indicated that the physician's order did not include the statement to notify the physician's for blood sugar less than 70 mg / dl. However, according to the LVN 1 and the original physician's order (hand written telephone order) there was physician's order to call the physician for blood sugar over 400 mg/dl and less than 70 mg/dl. According to the LVN 1 the order was not	F 281		

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F 281	Continued From page 3 accurately transcribed in the current physician's order and the licensed nurses needed to notify the physician regarding the resident's BS being less than 70 mg/dl. On March 19, 2012, at 7:40 a.m., during an interview with the LVN 2, she stated that as per facility's policy, the resident should have been provided orange juice when the blood sugar drops to 60 mg/dl, if not in conflict with the physician's order.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, 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 interview and record review, the facility failed to ensure that Resident 12 who had an elevated level of Potassium was monitored for signs and symptoms of hyperkalemia (abnormally high levels of potassium in the blood), for one out of 27 sample residents (12). Findings: a. According to the admission record, Resident 12 was admitted to the facility on September 1, 2006, with diagnoses that included congestive heart failure, diabetes mellitus and hypertension.	F 309	Resident #12 and all other residents on Kayexalate were identified and lab values reviewed. Signs and symptoms of hyperkalemia monitoring were care planned and documented. All RNs/LVNs were in-serviced. Director of Clinical Services will monitor residents on Kayexalate for hyperkalemia and report findings to QI Committee quarterly. Compliance threshold – 100%	04/06/12

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F 309	Continued From page 4 According to the Minimum Data Set (MDS) assessment dated December 30, 2012, the resident had moderately impaired cognitive skills for daily decision making and required assistance with activities of daily living. A review of the resident's laboratory test report dated March 6, 2012, indicated the resident had a Potassium level of 5.6 milliequivalents per liter (meq/ml) (reference range 3.5 to 5.0 meq/ml). According to the physician's order dated March 6, 2012, and review of Medication Administration Record (MAR) the resident was treated with Kayexalate 15 gram (gm) daily for three days for an elevated potassium level. There was a short-term plan of care dated March 6, 2012, for the Kayexalate therapy secondary to elevated potassium. The intervention was to monitor the resident for signs and symptoms of hyperkalemia such as numbness/tingling of extremities, mental confusion, weakness of limbs and flaccid paralysis. A review of the resident's clinical record and and an interview with the Director of Nursing (DON) on March 14, 2012, at 11:30 a.m., did not provide documented evidence the resident was monitored for signs and symptoms of hyperkalemia as stated on the plan of care. During the interview the DON stated the licensed nurses should have monitored the resident as care planned every shift.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322		

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F 322	Continued From page 5 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident fed by a gastrostomy tube (GT) was evaluated by a speech therapist (ST) before the resident was provided oral food and un thickened fluids in order to prevent the potential for aspiration for one out of 27 sample residents (15). Findings: On March 14, 2012, at 2 p.m., Resident 15 was observed in bed with the GT in place. The resident was receiving Glucerna at 70 cubic centimeters (cc) per hour. It was noted the resident had a meal tray at bed side with purred food and un-thickened regular milk, coffee and juice. The resident was not eating at the time of observation. According to the admission record, the resident was admitted to the facility on February 3, 2009, with diagnoses that included [redacted], diabetes and congestive heart failure. The Minimum Data Set (MDS) assessment dated January 23, 2012, indicated the resident had	F 322	Resident #27 was evaluated by speech therapist (ST) on 4/3/12. Her documentation in resident's medical record states to continue puree with regular texture liquid. No signs and symptoms of aspiration. All other residents with gastrostomy tube (GT) were identified. Feedings were provided as ordered by ST. All RNs/LVNs were in-serviced not to discontinue thickened fluids without an order by ST. Director of Clinical Services will monitor thickened fluids for appropriate consistency as ordered and report findings to QI Committee quarterly. Compliance threshold – 100%	04/06/12

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F 322	Continued From page 6 moderately impaired cognitive skills for daily decision making and was totally dependent on staff for activities of daily living. The MDS also indicated the resident was receiving nutrition through the GT. The physician's order dated August 11, 2011, indicated resident was on Glucerna at 65 cc per hour for 22 hours to provide 1430 cc/1430 calories daily and purred diet with no added salt and no concentrated sweet for oral gratification with nectar thickened fluids as ordered on November 3, 2011. According to the plan of care dated November 3, 2011, for the swallowing difficulty, the resident was identified to be at risk for aspiration. On February 1, 2012, there was a physician's order to increase Glucerna to 70 cc per hour for 22 hours to provide 1540 cc/1540 calories daily and on February 2, 2012, there was a physician's order to discontinue thickened fluids. A review of the resident's record indicated there was the ST's evaluation dated November 3, 2011. It was documented the ST was evaluating the resident for the safest diet texture for the resident's swallowing. The ST documented the resident had a delayed swallowing and recommended for the resident to have pureed food with nectar thickened fluids to prevent aspiration. ST also documented that according to the resident's son the resident's was gagging at times when he was feeding the resident. In the progress note dated November 3, 2011, the ST indicated that she will re-evaluate the resident's	F 322		

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F 322	Continued From page 7 swallowing ability upon the resident's improvement. A review of the resident's clinical record and an interview with the DON on March 15, 2012, at 12:20 p.m., revealed that after November 3, 2011, the ST did not evaluate the resident's swallowing skills for improvement and safety to advance fluids to a regular un-thickened fluids. The DON during the interview confirmed that the resident's nectar consistency fluids were discontinue without the ST evaluation. The DON further stated the resident had the GT placed per family decision due to the resident's extreme fatigue, weakness and poor food intake and not because of swallowing problem and the resident hardly consume food offered to her for oral gratification. A review of the resident's meal intake record for the month of March 2012, indicated the resident's oral food intake ranged from 10 to 35 percent.	F 322		