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

PRINTED: 11/16/2011
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
	055287	A. BUILDING _____ B. WING _____	10/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY PALMS CARE CENTER	13400 SHERMAN WAY N HOLLYWOOD, CA 91605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification Survey. Representing the Department of Public Health: [redacted], RN- HFEN [redacted], RN- HFEN Total Population: 86 Sample Size: 18 Highest S/S = G	F 000	By submitting this POC, Valley Palms Care Center does not admit nor concede the existence or scope and severity of the deficiencies and conditions cited in HCFA-2567 or all of the facts and conclusions as described in the summary statement. However, even as to alleged facts, conclusions, determinations or issues which Valley Palms Care Center may question or dispute, Valley Palms Care Center respects the concerns raised thereby. Valley Palms Care Center acknowledges there is always room for improvement and will endeavor to improve where all concerns are raised, whether Valley Palms Care Center agrees or not. This POC is submitted in compliance with Federal and State law and Valley Palms Care Center is aggressively implementing actions to improve operations and resident care in accordance with this POC.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide discharge planning by social services in participation with the interdisciplinary team (IDT) that included the physician for residents who expressed desire to return to the community (8, 16) and failed to ensure resident's belongings recorded on the inventory list were collected and signed for by the resident or their responsible party when the resident was discharged (16) for three out of 18 sample residents (8, 16, 18).	F 250		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruber Nuri | TITLE: Administrator | (X6) DATE: 11/29/11

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...llowing 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 ...ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...ogram participation.

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F 250	Continued From page 1 Findings: a. On October 26, 2011 at 1:15 p.m., during an interview Resident 8 stated he would rather be at home and he pulled out a set of keys from his pocket indicating they are the keys to his apartment and states, "This is my reality" referring to the keys in his hand. According to the admission record, Resident 8 was admitted to the facility on March 4, 2011, with diagnoses that included severe sinus bradycardia, abnormality of gait, and muscle weakness. The Initial Minimum Data Set (MDS) assessment dated March 11, 2011, indicated the resident had [redacted] for daily decision making and needed supervision with mobility and only needed limited assistance for most activities of daily living. The MDS assessment also indicated the resident's overall expectation was to be discharged to the community. However, there further assessment by the IDT that indicated if the resident's desire for discharge was realistic and initiate a discharge plan in participation of the resident. The Quarterly MDS assessment dated September 11, 2011, indicated improvements that included the resident's [redacted] for daily decision making had improved to modified independence, he was independent with mobility, and only needed supervision and setup support for most activities of daily living. Following the completion of the Quarterly MDS assessment there is no active discharge plan in place for the resident.	F 250	F - 250: Immediate Action Resident 8's discharge plan was reviewed and updated with the resident, and discharge to lower level of care initiated. The MediCal Waiver Program will be used for transfer and transfer accepted when approved. Resident 16's discharge plan was reviewed and updated with the resident and a plan to overcome financial barriers was developed and appropriate agencies contacted. The inventory items belonging to the discharged resident were disposed of per family request. Identification of other affected residents: All Residents have the potential to be affected. Systemic Changes: An in-service was conducted by the Administrator for the Interdisciplinary Team on 11/23/11 regarding discharge planning. An in-service was conducted by the Social Service Designee on 11/9/11 for nursing staff regarding resident inventory management. The Administrator conducted an in-service on 11/23/11 for Medical Records Designee and Social Service Designee on inventory records at time of discharge. Inventory lists for all discharged Residents for the prior 90 days were audited by Social Service Designee to ensure compliance. Quality Assurance: The Administrator or designee will review resident discharge planning on a routine basis to ensure completeness of plan and progress. The Administrator or designee will conduct routine inspections of closed charts and inventory areas to ensure proper Resident inventory management. Any unexpected findings will be reported to the QA Committee for further recommendations.	11/23/2011

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F 250	Continued From page 2 A review of the IDT quarterly conference record dated September 13, 2011, indicates there is no discharge plan at this time and the resident's desire to be discharged to the community was not addressed. According to the record there is no indication that the resident attended or participated in this quarterly conference including the reason why the resident did not participate was not documented. The section for the resident's participation was left blank on the IDT conference record. On October 27, 2011 at 4:45 p.m., during an interview with Social Services staff she indicated social services department had not developed any type of discharge plans for the resident. On October 31, 2011 at 12:30 p.m., during an interview with Registered Nurse 1 (RN 1) also indicated that an active discharge plan should have been developed for the resident. According to the facility's policy on Discharge Plan/Post Discharge Plan of Care Dated January 2004, the Discharge Planning Coordinator, with consultation from the interdisciplinary team, shall provide a discharge planning service and process, for each resident admitted, that identifies and evaluates the resident's needs and assists him/her in moving from one environment to another. b. On October 27, 2011 at 5:35 p.m. during an interview Resident 16 expressed a desire to be discharged from the facility and stated he would rather be at home because he could do things on his own or with minimum assistance on the days	F 250		

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F 250	Continued From page 3 he goes to dialysis, such as dressing, and walking. According to the admission record, Resident 16 was readmitted to the facility on March 4, 2011, with diagnoses that included end stage renal disease, and hypertension congestive heart failure. The Minimum Data Set (MDS) assessment dated August 21, 2011, indicated the resident was cognitively intact with skills for daily decision making and was independent with mobility and most activities of daily living except bathing where it indicates he needed extensive assistance. According to the MDS assessment the resident had expressed a desire for discharge to the community. Although the resident had expressed a desire to be discharged to the community, there further assessment by the IDT that indicated if the resident's desire for discharge was explored and a discharge plan initiated. According to the IDT quarterly conference record dated August 16, 2011 it indicates there is no discharge plan for the resident. According to the record it indicates the resident did not attend or participated in this quarterly conference and does not indicate a reason why the resident did not participate this section of the record was left blank. On October 27, 2011 at 4:46 p.m., during an interview with Social Services staff she indicated social services department had not developed any type of discharge plans for the resident.	F 250		

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F 250	Continued From page 4 On October 31, 2011 at 12:30 p.m., during an interview with Registered Nurse 1 (RN 1) also indicated that an active discharge plan should have been developed for the resident. A review of the facility's policy on Discharge Plan dated January 2004 indicates the Discharge Planning Coordinator, with consultation from the interdisciplinary team, shall provide a discharge planning service and process, for each resident admitted, that identifies and evaluates the resident's needs and assists him in moving from one environment to another. The purpose of discharge planning is to ensure that each resident has a planned program of continuing care which meets his post discharge plan of needs. c. On October 27, 2011 during a closed record review Resident 18 was readmitted to the facility on July 22, 2011, and transferred to the general acute care hospital on August 17, 2011. The resident did not return to the facility. A review of the resident's closed record indicated the resident had personal belonging listed on the Clothing and Possessions record dated July 22, 2011. According to the inventory list documented at the time of admission the resident had one dress, 2 socks, one blanket and one under shirt. A review of the discharge record dated August 17, 2011, indicates the resident's belongings "were still in the facility for possible return." On October 27, 2011, at 4:40 p.m., the Social services personnel during an interview stated the resident's belongings should have been disposed and a record of disposition maintained.	F 250		

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F 250	Continued From page 5 According to the facility's Policy and Procedure dated January 2004, the resident's personal belongings recorded on the inventory list is to be completed upon discharge and shall be signed by the resident/agent and a facility representative and the facility shall place the resident's belongings in safekeeping after the resident's discharge until the resident's representative is able to collect the resident's possessions.	F 250		
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 observation, interview and record review, the facility failed to ensure that emergency supplies were kept at the bedside for 2 residents on a hemodialysis treatment to effectively manage a potential emergency related to bleeding from the dialysis access site for one out of 16 sample residents (16). Findings: According to the admission record, Resident 16 was admitted to the facility on March 4, 2011 with diagnoses that included end stage renal failure and according to the physician's order	F 309		

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F 309	Continued From page 6 recapitulation for October 2011 readmitted on September 3, 2011. The Minimum Data Set (MDS) assessment dated August 21, 2011, indicated the resident was [redacted] for daily decision making and was independent with only setup support with activities of daily living. The resident had a physician's order dated September 3, 2011, for hemodialysis three times a week and another physician's order with the same date to monitor hemodialysis site for bleeding every shift. During the survey from October 27, 2011 to October 31, 2011, between the hours of 8 a.m. to 5:30 p.m., there was no emergency set up observed in the resident's room to manage a potential emergency related to bleeding from the hemodialysis access site. On October 31, 2011, at 10:25 a.m., during an interview with Certified Nursing Assistant 1 (CNA 1), he indicated if the resident had bleeding from the hemodialysis access site he would report to the charge nurse. He added that he had not had an in-service regarding emergency procedure to follow if a resident's hemodialysis access site was bleeding. On October 31, 2011, at 10:45 a.m. during another interview with Licensed Vocational Nurse 4 (LVN 4) she stated that if the resident's hemodialysis access site started bleeding she would apply pressure dressings over the access site. She added that an emergency supply of dressings and Kerlix gauze rolls were in the	F 309	F- 309 Immediate Action: Resident 16's emergency supply set up at bed side was provided immediately and bed side drawers were cleaned and re-organized. Identification of other affected Residents: All hemodialysis Residents have the potential to be affected. Systemic Changes: All hemodialysis Residents' bedside areas were checked for complete emergency supply set up and bedside drawers organized. The Director of Nurses in-serviced licensed nurses on 10/31/11- 11/9/11 regarding emergency setup for hemodialysis Residents. The Staff Developer conducted in-service training on emergency supply setup for CNA's on 11/9/11. All new Residents with same condition will have the same setup. Quality Assurance: The nurse executive team will conduct routine inspections to ensure that setup is in place and easily accessible. Any unexpected findings will be reported to the QA Committee for further recommendations.	11/09/2011

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F 309	Continued From page 7 nightstand drawer in the resident's room. However, during observation inside a cluttered the nightstand drawer, LVN 4 was unable to find any emergency supplies as she had stated during the interview. On October 31, 2011 at 12:40 p.m., RN 1 stated all hemodialysis resident's should have emergency supply set up at the bed side in case of bleeding from the hemodialysis site.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent a fall from a Hoyer Lift (an assistive hydraulic lift/hoist device used to lift a resident) that resulted in an injury to the head that required repair with three staples for one random sample resident (Resident 20) by failing to: 1. Develop a plan of care based on the comprehensive assessment information that indicated the resident required a two-person physical assist during transfers. 2. Ensure that a resident assessed as requiring a two-person assist with transfers was not transferred by a single person from bed to a	F 323		

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F 323	Continued From page 8 Geri-chair (health care equipment-chair that can be adjusted to multiple positions from fully upright to fully reclined), using a Hoyer Lift. Findings: On October 27, 2011, at 12:25 p.m., Resident 20 was observed in bed in her room with Certified Nursing Assistant 5 (CNA 5) present. When asked, CNA 5 stated that the resident had a head injury from a fall. Resident 20's laceration (a jagged wound or cut) injury to the right side of the head was observed with the assistance of CNA 5. The laceration measured 2.0 centimeters (cm), was dry without drainage, and was repaired with three staples. There was no dressing over the staples. The family member also present in the room stated the incident occurred while a single staff member transferred the resident. On October 27, 2011 at 12:35 p.m., during an interview, Resident 20's family member stated that Resident 20 fell and sustained a head injury during a transfer from the Geri-chair to the bed. According to the admission record, Resident 20 was admitted to the facility on August 1, 2011, with diagnoses that included cerebrovascular accident, [(CVA) a stroke, a disruption of the blood supply to the brain] abnormal posture, [redacted]/encephalopathy (brain dysfunction caused by illnesses), and severe generalized weakness. The Fall Risk assessment dated August 1, 2011, indicated the resident had a total score of ten. According to the assessment tool, a score of ten or above represents a high risk for falls. The comprehensive Minimum Data Set (MDS) assessment dated August 7, 2011, indicated the [redacted], associated with confusion,	F 323	F – 323: Immediate Action: Resident 20's Care Plan was updated to ensure proper care delivery, and safety in-services conducted specific to Resident care plan provided on 10/21/11. The employee involved was suspended 10/21/11. Identification of other affected Residents: All Residents who require a 2-plus person assist for transfers have the potential to be affected. Systemic Changes: All Residents requiring a 2-plus person assist care plans were reviewed for completeness as to interventions related to transfers. In-services were conducted for nursing staff between 10/21/11 – 11/23/11 regarding safe lifting and moving Residents, and proper assistance. In-services included competency skills check regarding use of mechanical lift/Hoyer Lift and 2-plus person assist. The Director of Nurses conducted an in-service to license nurses regarding Resident transfer requiring two person assist. Quality Assurance: Administrator, Medical Records and/or designee will conduct routine audits to ensure that care plans direct nursing staff on how to transfer Residents. Nurse Executive Team will conduct random checks to observe nursing staff in transferring Residents. Unexpected findings will be reported to the QA Committee for recommendations.	11/23/2011

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F 323	Continued From page 9	F 323		

forgetfulness and difficulty concentrating) skills for daily decision making, was totally dependent on staff for mobility, transfers, activities of daily living [ADL- is a term used in healthcare to refer to daily self-care activities within an individual's place of residence], and required a two-plus person physical assist with mobility and transfers. She was 67 inches in height, and weighed 146 pounds.

Although the Fall Risk assessment indicated the resident was a high risk for falls, and the MDS assessment indicated she required a two-plus person physical assist with mobility and transfers, a plan of care was not initiated to direct the nursing staff on how to transfer the resident.
The plan of care initiated on September 8, 2011, one month after the completion of the MDS assessment, indicated the resident had a potential risk for fall/injury. The goal in the care plan stated the resident would not have injuries "as much as possible" for the next three months. The interventions on the plan of care included to keep the environment safe and observe safety precautions at all times. The care plan did not include interventions related to the use of a two-person assist during transfers as required in the comprehensive assessment.
There was another plan of care dated September 8, 2011, that indicated the resident had a self-care deficit and impaired mobility related to CVA and dementia. The plan of care did not include intervention related to the use of a two-person physical assist during transfers.
A review of the Nurses Notes dated October 21, 2011 at 2 p.m., revealed during a transfer using a Hoyer Lift, the resident fell and landed on the floor in a supine (lying on the back or having the face

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F 323	Continued From page 10 upward) position. According to the notes, the resident was awake, and responsive, with minimum bleeding from the back of the head. The resident was assessed with a cut on the right occipital (area at the back of the head) area, that measured approximately 2.0 cm long, a depth 0.4 cm. Pressure was applied to the cut, and the resident was assessed for pain rated at 6 out of 10 (on a 0 to 10 pain rating scale with ten being the worst pain). The physician was notified and at 2:30 p.m., ordered the resident to be transferred to the general acute care hospital (GACH) for further evaluation. According to the Interdisciplinary Notes records dated October 21, 2011, the resident fell while CNA 4 transferred her from a Geri-chair to a bed using a Hoyer Lift. According to the record, CNA 4 stated the resident made a sudden movement which caused her to slide out of the Hoyer lift sling and fall to the floor. The record indicated the resident was not interviewable to provide an account of the incident due to cognitive impairment and inability to communicate. According to the facility's investigation report, CNA 4 stated she transferred the resident with the use of the Hoyer Lift by herself and she did not call for assistance from other nursing staff. The facility terminated CNA 4 following this incident and therefore was not available for an interview. A review of the In-service Record of Attendance dated May 4, 2011, revealed CNA 4 had attended an in-service that included a discussion of mechanical lift devices where the manufacturer's guidelines for Hoyer Lifts were discussed. A review of the manufacturer's instructions for the use of a Hoyer Lift for transfers recommends that	F 323		

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F 323	Continued From page 11 " ...two assistants be used for all lifting preparation, transferring from and transferring to procedures. The use of one assistant is totally based on the evaluation of the health care professional for each individual case." A review of the Emergency Department (ED) report obtained from the GACH dated October 21, 2011, the resident was brought to the ED due to an injury from a fall and blunt head trauma on the back of her head leading to a 2.0 cm scalp laceration on her posterior right occipital scalp region that was repaired with staples. The resident had extensive imaging studies all of which indicated no fractures or cerebral bleeding. The ED report indicated the resident was stable and was discharged back to the facility on the same date. On October 31, 2011, at approximately 5:35 p.m.; during an interview Registered Nurse 1 (RN 1) stated the resident should have been transferred with a two-person assist. A review of the facility's policies (Revised August 2009), on Safe Lifting and Movement of Residents and on Fall/Accident Mitigation and Intervention indicated that nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. The resident's transferring and lifting needs will be documented in the care plan, the risk factors will be identified for that individual resident, and appropriate interventions will be done based on the risk factors.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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	055287	A. BUILDING _____ B. WING _____	10/31/2011

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F 329	Continued From page 12 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor for the resident for baseline serum iron or ferritin level and periodic laboratory tests such as complete blood count (CBC) or hematocrit/ hemoglobin when Ferrous sulfate was ordered for a long-term use to prevent the potential of accumulation of iron in the tissue if used for a long duration and failed to monitor the heart rate of a resident on Albuterol for one out of one out of 18 sample residents (13). Findings:	F 329	F-329: Immediate Action: Resident 13's physician provided an order for CBC on 10/27/11; findings within normal range. Order for Ferrous Sulfate was discontinued. Heart rate and blood pressure monitoring after Albuterol administration orders were obtained and initiated on 10/26/11. Identification of other affected Residents: All Residents have the potential to be affected. Systemic Changes: The Pharmacist conducted medication regimen review on 11/1/11. All Residents with orders for Ferrous Sulfate for anemia were audited to ensure proper monitoring. For all Residents with orders for Albuterol, orders for monitoring of Albuterol were obtained. The Director of Nurses and clinical resource conducted in-services for licensed nurses regarding monitoring for ferrous sulfate and Albuterol on 10/26/11 – 11/23/11. The pharmacy provider was contacted, findings shared and pharmacy will provide training for Pharmacists and consultants regarding State Ops Manual recommendations for medication monitoring. Quality Assurance: Medical Records and nurse executive team will monitor orders regarding Ferrous Sulfate and Albuterol routinely. Results will be compiled monthly and shared with the QA Committee for further recommendation.	11/23/2011

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F 329	Continued From page 13	F 329		

a. According to the admission record, Resident 13 was admitted to the facility on December 1, 2008, with diagnoses that included hypertension, chronic obstructive pulmonary disease (COPD), debility and anemia.

The Minimum Data Set (MDS) assessment dated August 21, 2011, indicated the resident was [redacted] for daily decision-making and needed extensive assistance from staff members for all activities of daily living (ADL) except in eating and walk in corridor.

The resident had a physician's orders dated April 29, 2010, for Ferrous Sulfate 325 milligrams (mg) everyday by mouth with food.

A plan of care dated December 20, 2008, indicated activity intolerance and potential for anemia. The approaches were included medication as ordered, laboratory test as ordered and report abnormals promptly.

The Medication Administration Records indicated the resident had received Ferrous Sulfate every day as the physician ordered for over eighteen months. However, there was no documented evidence the laboratory tests such as baseline serum iron or ferritin level, CBC, hematocrit/ hemoglobin were done to monitor possible iron accumulation in the resident's tissue, and/or documentation that indicated the clinical rationale for a long-term use of iron.

On October 26, 2011, at 10:30 a.m., during an interview, Registered Nurse 1 (RN 1) was unable

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F 329	Continued From page 14 to find the iron level in the chart and stated the resident should have been monitored for the possible iron accumulation. According to the State Operation Manual (SOM), clinical rationale should be documented if iron is ordered for a log-term use (greater than two months) or if administered more than once daily (daily for greater than a week), because of side effects and the risk of accumulation of iron in the tissues. Monitoring the baseline serum iron or ferritin level and periodic complete blood count (CBC) or hematocrit/ hemoglobin is needed. Adverse consequences includes constipation, dyspepsia, accumulation of iron in tissues that cause multiple complications if given chronically despite normal or high iron stores (SOM, October 2010, Page 390). b. Resident 13 also had a physician's order dated October 2, 2011, for Albuterol HFA 90 micrograms (mcg) two puffs inhalation for COPD two times per day. On October 26, 2011, at 8:50 a.m. during a medication pass observation Licensed Vocational Nurse 2 (LVN 2) administered one puff of Albuterol inhalation into the resident's mouth, and administered another puff of Albuterol at a one minute interval. LVN 2 did not monitor the resident's heart rate before and after administering Albuterol. In addition, a review of the Medication Administration Record (MAR) from October 2, 2011, to October 26, 2011, did not indicated the licensed nurses who administered Albuterol to the resident twice daily at 9 a.m. and 5 p.m. had	F 329		

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F 329	Continued From page 15 monitored the resident's heart rate. According to Nursing 2010, Drug Handbook (Lippincott: Williams & Wilkins), indicated albuterol sulfate is a drug classified under bronchodilators used to prevent or treat bronchospasm in patients with reversible obstructive airway disease. Adverse reactions included were tachycardia, palpitations, and hypertension. Contraindications and cautions included were to use cautiously in patients with cardiovascular disorders. On October 31, 2011, at 9:35 a.m. during an interview, Registered Nurse 1, stated the resident's heart rate should have been monitored upon administration of albuterol.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		

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F 334	Continued From page 16 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334	F – 334 Immediate Action: Resident 14 had been discharged so no action could be taken at that time. Identification of other affected Residents: All Residents have the potential to be affected. Systemic Changes: Whole facility immunization program was audited on 10/30/11 and updated as necessary. The Director of Nurses conducted in-service training on 11/2/11-11/23/11 for Licensed Nurses regarding pneumococcal vaccine administration and policy and procedures. Quality Assurance: Director of Nurses, Medical Records and/or designee will conduct routine audits to ensure compliance. Any unexpected findings will be reported to the QA Committee for recommendations.	11/23/2011

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F 334	Continued From page 17 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow-up on a resident's vaccination status for pneumonia for one out of 18 sample residents (14). Findings: According to the admission record, Resident 14 was admitted to the facility on April 6, 2011, with diagnoses that included [redacted], [redacted], and muscle weakness. The Minimum Data Set (MDS) assessment dated April 12, 2011, indicated the pneumococcal vaccine was not coded. A review of the Immunization Log of the resident, it was blank on the section of pneumococcal vaccine. There was no information in the resident's clinical record indicating if the resident's pneumococcal vaccine status was updated or not. On October 28, 2011, at 10:55 a.m. during an interview with Registered Nurse 1 who was responsible for coordinating and implementing the facility's immunization program, she was not able to provide any documentation in the clinical record whether the resident's pneumococcal	F 334		

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F 334	Continued From page 18 vaccine status was updated, and whether the resident or the responsible party was notified of the pneumococcal vaccine status in order to give them the opportunity to make a decision regarding the administration of the pneumococcal vaccination. A review of the facility's policy of Flu and Pneumococcal Vaccine Administration indicated it is the policy of the facility to provide flu and pneumococcal vaccines to the residents in accordance with Center for Disease Control (CDC) recommendations and the physician's order. The resident or responsible part/legal representative will be given the information to make a decision regarding the administration of the pneumococcal or flu vaccination during the admission process.	F 334		
F 371 SS=F	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 and interview, the kitchen staff failed to store food appropriately and maintain the kitchen in a clean and sanitary manner, with the potential to affect all residents in	F 371		

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F 371	Continued From page 19 the facility. Findings: During an observation of the kitchen on October 25, 2011 between 8:30 a.m. and 10:10 a.m. and on October 31, 2011 at approximately 9:15 a.m. the following was observed: 1. In the pantry there were two different can products that had old and deteriorated labels and the expiration dates were not clear (a) Pickle Spears Kosher Style Heinz brand 99 fluid ounces times 3 cans (b) Vanilla Pudding and Pie filling Mix 24 ounces. 2. Water Chestnuts Jack Pot brand 6 pounds 8 ounces (one can) was dented. During an interview with the dietary supervisor, she stated these products should not be stored with the ready to use items, she pointed to a designated place outside the pantry where these items should have been placed. 3. The door handles and hinges on the refrigerator next to the steam table were sticky and had visible accumulated grease and grime and the shelves in this refrigerator had rust along the edges. The floor area around this refrigerator had accumulated dirt. 4. The electrical metal boxes under the steam table had an accumulation of dirt and dust clumps. 5. Four muffin pans had an accumulation of black dried grease all around the underside of the pans.	F 371	F – 371: Immediate Action: On 10/25/11 all cans in the food supply were inspected for integrity, proper labeling and expiration dates, and discarded as necessary. The refrigerator and steam table were immediately cleaned. Muffin pans were replaced with new ones. The drain pipe was modified to ensure a proper air gap. Identification of other affected Residents: All Residents have the potential to be affected. Systemic Changes: The facility food storage program was evaluated to ensure that cans are stored in a way that they won't be damaged. The manufacturer provided Julian code information so that the facility can determine expiration dates for canned goods. The Registered Dietician provided an in-service to the Dietary Supervisor regarding the codes on 10/31/11. Kitchen cleaning and deep cleaning schedules and logs were revised to ensure a sanitary environment. Kitchen cooking instruments were inspected for cleanliness and sanitation. Quality Assurance: Administrator, Director of Nurses and/or Registered Dietitian will conduct periodic inspections to examine food storage conditions, surfaces, equipment and instruments for cleanliness and condition, and logs for completeness. Any unexpected findings will be reported the QA Committee for recommendations.	11/02/2011

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F 371	Continued From page 20 6. The drain pipe leading from the walk-in refrigerator did not have an air gap with the floor sink it was inside the floor sink.	F 371		
F 425 SS=D	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 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's mouth was rinsed out after inhalation of steroid medication (Flovent), and the iron supplement (Ferrous Sulfate) was administered with the food as the physician ordered for one out of 18 sample residents (13).	F 425	F – 425: Immediate Action: 11/01/2011 On 10/26/11 LVN 2 was provided one-to-one in-service regarding administration of inhalers, timely medication administration (including meal times). Resident 13 was assessed and placed on 72-hour monitoring. Physician was notified. Identification of other affected Residents All Residents have the potential to be affected. Systemic Changes The Director of Nurses in-serviced licensed nurses on 10/27/11 regarding proper administration of inhalers and timelines. Pharmacist provided medication administration observation during facility visit. Quality Assurance The Pharmacist, pharmacy consultant and Director of Nurses will conduct medication administration observation of licensed nurses on a routine basis with feedback for performance improvement. Any unexpected findings will be reported to the QA Committee for recommendations.	

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F 425	Continued From page 21	F 425		

Findings:

a. According to the admission record, Resident 13 was admitted to the facility on December 1, 2008, with diagnoses that included hypertension, debility and anemia.

The Minimum Data Set (MDS) assessment dated August 21, 2011, indicated the resident was moderately impaired for cognitive skills for daily decision-making and needed extensive assistance from staff members for all activities of daily living (ADL) except in eating and walking in corridor.

The resident had a physician's order dated October 2, 2011, for Flovent 44 two puffs two times per day for chronic obstructive pulmonary disease (COPD).

According to the State Operation Manual (SOM), Flovent is a corticosteroid medications, and inhaled steroids can cause throat irritation and oral candidiasis, especially if the mouth is not rinsed after administration. (SOM, October 2010, Page 393 and 394).

On October 26, 2011, at 8:50 a.m. during a medication pass observation for the resident, Licensed Vocational Nurse 2 (LVN 2) administered the first puff of Flovent inhalation. The resident took a sip of water after the first Flovent inhalation but did not rinse her mouth. After one minute, LVN 2 administered the second puff of Flovent inhalation. The resident took another sip of water again instead of rinsing her mouth out because the licensed nurse dide not

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F 425	Continued From page 22 instruct the resident. During an interview with LVN 2 after she finished administering Flovent inhalation, she stated she let the resident drink the sip of water because the resident wanted to drink a sip of water. LVN 2 was not aware of the need to rinse out the mouth after Flovent inhalation. A review of the facility's oral inhalation administration guideline indicated if receiving an inhaler containing steroid, the resident should rinse his/her mouth and spit out the rinsed water after final dose, and not to swallow it. b. Resident 13 had a physician's order dated April 29, 2010, for Ferrous Sulfate 325 milligram (mg) everyday with food (supplement). On October 26, 2011, at 8:50 a.m. during a medication pass observation, LVN 2 administered nine different medications to the resident by orally. On the same day at 9:20 a.m., LVN 2 approached to Evaluator and stated that she had omitted Ferrous Sulfate 325 mg one tablet by mistake and she administered Ferrous Sulfate 325 mg one tablet to the resident. However, she did not administer the medication with the food or food supplement. After LVN 2 administered the medication, she agreed that she should have administered the medication with the food as the physician ordered. A review of the Medication Administration Record (MAR) from May 2010, to October 2011, indicated the medication was scheduled to be administered at 7:15 a.m.	F 425		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=D	Continued From page 23 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, 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:	F 431	F-431 Immediate Action: All expired items were disposed of immediately per facility policy. Identification of other affected Residents All Residents have the potential to be affected. Systemic Changes: The Director of Nurses provided in-service training to licensed nurses on 10/25/11 – 11/23/11 regarding storing medical supplies and checking for expiration dates prior to use. An in-service was provided to the Central Supply and Treatment Nurse on supply management and expiration dates. Quality Assurance: The nurse executive team will conduct routine inspections of utility rooms on a routines basis to ensure compliance. Any unexpected findings will be reported to the QA Committee for recommendations.	11/23/2011

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	055287	A. BUILDING _____ B. WING _____	10/31/2011

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F 431	Continued From page 24 Based on observation and interview, the facility failed to ensure sterile dressing supplies were not stored in the utility room beyond the expiration date, and failed to ensure that discontinued medications were marked "discontinued" and stored separately as indicated in the facility's policy procedure and/or disposed after the resident's was discharged. Findings: a. On October 25, 2011, at 2:15 p.m., during medication storage inspection on Nursing Station II., the following was observed: 1. There was a bottle of Prostat (30 ounce) had expired on July 2011. 2. There were three sterile package of Xeroform (dressing suplly) expired on October 2008. 3. There were thirty packages of colactive collagen (dressing supplly expired on September 2, 2011, and on on July 13, 2008. During an interview with Licensed Vocational Nurse 3 (LVN 3) at the same time, she stated expired items should have not been stored in the utility room. b. On October 25, 2011 at 1:15 p.m., during an inspection of the medication storage room in Nursing Station I a medication bottle labeled Nexium 40 milligram, containing approximately 20 purple capsules was left in a counter drawer. During an interview on the same day at 1:20 p.m. with Licensed Vocational Nurse 4 (LVN 4) she stated that the medication belonged to a resident	F 431		

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F 431	Continued From page 25 who had been discharged from the facility long ago and should have been given to the director of nursing and not left in the drawer. A review of the facility's policy on Disposal of Medications and Medication-Related Supplies dated April 2008 indicated that when medications are discontinued when a resident is discharged and does not take medications with him/her, the medications are marked as "discontinued" or stored in a separate location designated solely for this purpose.	F 431		
F 441 SS=F	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	F 441		

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F 441	Continued From page 26 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 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the use of proper disinfectant while cleaning a room occupied by a resident infected with Clostridium Difficile (C-diff) and who was on contact isolation to prevent the potential of the spread of organism for one resident (1), with the potential to affect all residents, failed to properly store enteral feeding formula tubing and not touched the floor to prevent contamination, failed to observed infection control procedures that included handwashing, using gloves when appropriate and removing dirty gloves to prevent the spread of infection through cross contamination for one random sample resident (21) and for two out of 18 sample residents (1,7). Findings: 2. According to the admission record, Resident 1 was originally admitted to the facility on September 18, 2002, and readmitted on May 27,	F 441	F – 441; Immediate Action: For Resident 1, the enteral tube feeding formula and tubing were changed immediately on 10/25/11. HKP1 was in-serviced on 10/27/11 regarding proper chemical for cleaning isolation rooms. CNA 2 was in-serviced regarding hand hygiene on 10/31/11. CNA 3 was in-serviced regarding isolation precautions on 10/31/11. Identification of other affected Residents: All Residents have the potential to be affected. Systemic Changes: All Residents on enteral feeding were checked to ensure that tubes and related equipment was maintained properly. Licensed nurses were in-serviced by Director of Nurses on 11/1/11 -11/7/11 regarding tube feeding equipment. Housekeeping staff were observed for proper chemical preparation and application. The chemical supply company reviewed the facility chemical use; clarification was provided by the Infection Control Consultant; Facility policies were reviewed for procedure. The Director of Staff Development conducted in-service training on 11/9/11 to Facility staff regarding infection control, hand hygiene, contact isolation precaution, and policy and procedures were reviewed.	~~10/27/2011~~ 11/23/11

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F 441	Continued From page 27 2011 with diagnoses that included dysphagia and jejunostomy tube feeding. The resident had a physician's order dated October 20, 2011, for Fibersource HN at 50 cubic centimeter (cc) per hour for 20 hours. On October 25, 2011, at 8:50 a.m., the resident was observed lying in her bed and she had a jejunostomy tube used for feeding. There was a bottle of Fibersource formula with tubing hung on an enteral pump machine next to the resident but at the time of the observation, the tubing was not connected to the jejunostomy tube and a part of the tubing was on the floor and the enteral feeding pump was turned off. During an interview with Licensed Vocational Nurse 2 present at the time of the observation, she stated when asked about the tube touching the floor, she stated the tubing should have been properly stored in protective bag when not in use and should have not touched the floor. b. On October 26, 2011, at 9:35 a.m., housekeeping personnel 1 was observed in the utility room preparing cleaning solution for a room which was on contact isolation for C-diff. During interviews with the maintenance supervisor and Housekeeping Ppersonnel 1 (HKP 1) at the time of the observation, they stated one of the chemical solution contained in the bottle was bleach, and the personnel from the chemical supply company had set the machine that the chemical automatically mixed with the water that made the dilution ratio one to ten (one part of chemical and ten part of water).	F 441	On 11/1/11 and 11/2/11 in-services were given to licensed nurses regarding enteral tube feeding administration. Quality Assurance The Administrator, nurse executive team, interdisciplinary team and/or designee will conduct routine observation of all aspects of infection control to ensure compliance. During weekly visits rounds will be conducted to verify compliance. Any unexpected findings will reported to the QA Committee for recommendations.	

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F 441	Continued From page 28 On the same day at 9:40 a.m. during an observation of cleaning Room 27 that was on contact isolation with C-diff, the house keeping personnel cleaned the overbed table, night table, call light, and floor with the cleaning solution which was premixed with water and the chemical (the one they claimed it contained bleach) according to the set up by the chemical supply company personnel. A review of the manufacture's guideline of the chemical that was used cleaning the Room 27 which was on contact isolation with C- diff, indicated the ingredient was ammonium chloride and the direction of dilution rate was 1 part of disinfectant to 64 part of water. Also, it was not indicated the solution was effective against C-diff. On October 28, 2011, at 10:45 a.m. during an interview with the administrative staff and Registered Nurse 1, they were not able to provide any documented evidence the disinfectant solution was mixed with one part of disinfectant and 10 part of water, and confirmed the disinfectant solution did not contain bleachee. A review of the facility's policy of infection control of C-diff indicated the disinfectant recommended for cleaning the environment of the resident with C-diff is a bleach solution with dilution of 1:10 (one part bleach to 10 parts water). b. On October 26, 2011 at 1:50 p.m., Certified Nursing Assistant 2 (CNA 2) was observed providing care to Resident 7. CNA 2 had on a pair of gloves while cleaning and changing the resident's briefs after the resident had a bowel movement. while cleaning the resident CNA 2	F 441		

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F 441	Continued From page 29 went into the bathroom twice to rinse a towel closing the door behind her. Then returned to the resident's bedside and opened the nightstand drawer to obtain A & D skin protective ointment, applied the ointment, padded the resident's hand and bare abdomen and removed her gloves and disposed of them in the trash. CNA 2 touched fomites (inanimate object or substance that is capable of transmitting infectious organisms from one individual to another) and resident's body parts with her soiled gloves and did not wash her hands. A review of the facility's policy on Hand washing/Hand Hygiene the CNA must wash her hands before and after direct resident contact and contact with a resident's excretions. During an interview with CNA 2 on October 26, 2011 at 2 P.M., she stated that she should have taken her gloves off and washed her hands after she finished cleaning the resident. c. On October 25, 2011 during the initial tour of the facility in the presence of Registered Nurse 1 (RN 1), it was noted that Resident 21 was in contact isolation for ESBL (Extended Spectrum Beta-Lactamase organisms are bacteria that are found in the bowel, urine, blood, skin wounds or sputum and can be spread directly by person-to-person contact and indirectly from contaminated surfaces to a person) of the urine. RN 1 stated that a gown and gloves would be needed to be used by persons entering the resident's room. There was a three drawers cart containing gowns and gloves outside the resident's room.	F 441		

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F 441	Continued From page 30 On October 26, 2011 at 6 p.m. CNA 3 was observed distributing dinner trays and went into the resident's room to set up the dinner tray. The CNA did not use a gown or gloves to enter the contact isolation room. The resident was observed lying in bed, the CNA placed the dinner tray on the roll-away table, adjusted the table, touched the foot of the bed as he was walking out of the room without washing her hands and proceeded to push the dinner tray cart to the next room where he went in adjusted the privacy curtains and floor pads. On October 26, 2011 at 6:10 p.m., during an interview with CNA 3, he stated that he didn't think he needed to wear a gown and gloves since he did not touch the resident. A review of the facility's policy on Hand washing/Hand Hygiene the CNA must wash his hands before and after entering isolation precaution settings.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain a clean, functional, comfortable environment and ensured the window frames were in good repair at all times for the residents.	F 465		

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F 465	Continued From page 31 Findings: a. On October 25, 2011, at 9:30 a.m. and at 9:40 a.m., the following was observed: 1. The closet drawers of Rooms 31 Bed-C and 34 Bed-C were observed out of track and not closed. 2. The bed linen of Room 36 Bed-C was observed to be very thin and worn out. b. On October 28, 2011, between 12:10 p.m. to 1 p.m. during the tour of the facility, in the presence of the maintenance supervisor, the following was observed: 1. Janitorial carts were observed stored in the shower rooms on Nursing Station I and II. During an interview with maintenance supervisor he stated those janitor carts should not have been stored in the shower room. 2. There were black grouts and rusty stains observed on the tile floor of a shower room in Nursing Station II. 3. The screen window frames were bent or not fitting in the window in Rooms 1, 5, 12,15, 22,18, 24, 25, 29, 30, 31 and 33. 4. There was approximately one foot of stain in diameter on the ceiling in Room 22's bathroom.	F 465	F-465: Immediate Action: Closet drawers in rooms 31c and 34C were repaired on 10/25/11. On 10/25/11 room 36C bed linens were immediately removed. All linens were inspected and any worn out lines were replaced with new ones. Janitorial carts are stored in the janitor closet and maintenance storage and are locked when are not in use. Shower room in station B was deep cleaned and disinfected on 10/26/11. Screens in rooms 1, 5, 12, 15, 22, 18, 24, 25, 29, 30, 31 & 33 were replaced. The stain in room 22, bathroom ceiling was cleaned and painted. Identification of other affected Residents: All Residents have the potential to be affected. Systemic Changes Shower areas in station A were examined to make sure tile floors are cleaned properly. On 10/25/11- 10/27/11 linens were inspected and any worn out lines were replaced with new ones. Housekeeping routine and deep cleaning schedule was modified to meet the needs of the facility. An in-service was conducted for Facility staff on 11/25/11 regarding use of the Maintenance Log and reporting any other concerns. The new Maintenance Supervisor was oriented to survey findings, and approved of logs and schedules. Quality Assurance: Administrator, Maintenance Supervisor and/or designee will conduct routine rounds and full monthly inspections of facility areas. Any findings will be corrected. Unexpected findings will be reported to the QA Committee for recommendations.	11/25/2011