STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHAB	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(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 California Department of Public Health during a recertification survey conducted from 8/30/11 to 9/2/11. Representing the Department: 26654, 22707, 27519, and 29539, HFENs Census: 96 Sample size: 20	F 000	Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies.	9/15/11
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed keep Resident 7 free from the use of a physical restraint, and failed to assess, initiate a care plan, and obtain a physician's order including a medical reason for the physical restraint used on Resident 7. Findings: Resident 7 was admitted to the facility on 8/16/11 with diagnoses that included a seizure disorder. During an observation on 8/31/11 at 9:30 am, Resident 7 was observed in his room sitting up in a high backed wheelchair. There was a "lap buddy" (a soft laptop cushion) in place inserted	F 221	This plan of correction is prepared and or executed soley because required by the provisions of health safety code section 1280 and 42 CFR 405.1907.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/16/11

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 221 Continued From page 1

into the sides of the wheelchair and extending across the front of the resident. Resident 7 was asked to remove the lap buddy. He was unable to demonstrate that he could remove it and made the statement, "I can't."

During an interview on 8/31/11 at 9:30 am, Licensed Nurse C stated that Resident 7 was unable to remove the lap buddy when she asked him to do it.

During an interview on 9/1/11 at 11:10 am, Licensed Nurse D stated that Resident 7 did have the strength to get up out of his wheelchair.

The clinical record for Resident 7 was reviewed on 8/31/11. There was no documentation to indicate there was a physician's order for the restraint. Also, there was no documentation of assessment, care planning, or monitoring for the use of a restraint on Resident 7's.

The facility's policy and procedure titled, "Use of Restraints" dated 12/08, indicated, "Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints" and " Restraints shall only be used upon the written order of a physician and after obtaining a consent from the resident and/or representative."

F 253 SS=E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

F 221

F221

A.
For resident #7, an assessment was done, care plan was created and an order from the physician was obtained which included the reason for the lap buddy by the physical therapist from the attending physician. This lap buddy is for positioning and to prevent the resident from sliding out of wheel chair. This resident has a diagnosis of Huntington's Chorea that makes him very susceptible to slipping out of chair.

9/15/11

B.
All residents in the facility shall be audited to ensure that any physical means of restraint or positioning be assessed. Any new order for physical restraint shall have state a medical reason, be properly care planned and be re -evaluated quarterly.

F 253

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	555673	A. BUILDING _____ B. WING _____	09/02/2011

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F 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a safe and sanitary environment in five resident rooms. (Rooms 30, 31, 32, 33, and 35) *Rooms 30 through Room 33's sliding glass door tracts contained a thick layer of black dirt, dried leaves, and cigarette butts. *Room 35 had a broken window sill which exposed a 15 inch sharp and pointed strip of wood just above a resident's bed. *Room 7 was not free of hazards during the initial tour. This could potentially cause the residents to have allergic reactions to dirt and leaves and expose them to bacteria from cigarette butts and be physically injured from pointed objects and folding chairs. Findings: 1. On 8/30/11 at 10:15 am, during the initial tour, an observation was made of Resident Rooms 30, 31, 32, and 33. The sliding glass door tracts in all four rooms contained a thick coat of black dirt, dried leaves, and cigarette butts. During an observation and concurrent interview on 8/31/11 at 10 am, Housekeeping Staff (HK) F confirmed that the sliding glass door tracts contained a thick layer of black dirt, dried leaves, and cigarette butts. HK F added that the tracts should have been cleaned by the housekeeping	F 253	C. The facility created a safety interventions matrix that updates all physician orders for side rails, lap buddy, tab alarms, low bed, amongst other orders for a reference guide for all staff This system updated as physician ordersare added or changed. There shall be two safety interventions reference guides available for staff review at each nursing station. D. The physical therapist on staff shall monitor the physical restraints and safety interventions ensuring that the devices are properly applied with assessment, orders, and medical reason weekly. A report to the QAAC 3 months from now will report on compliance. If there is not substantial compliance, the QAAC shall make recommendations for further review, assessment and interventions.	9/05/11

(7

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F 253	Continued From page 3 staff. 2. On 8/30/11 at 10:30 am, during the initial tour, an observation was made of Resident Room 35. A 15 inch sharp and pointed piece of wood had split from the broken window sill. The sharp pointed edge protruded directly toward the top right side of the resident's bed. During an observation and concurrent interview on 8/31/11 at 9:45 am, Maintenance Staff G confirmed that the window sill was broken, and sharp, and posed a safety hazard to the residents. 3. During the initial tour and concurrent interview on 8/30/11 at 11 am, the surveyor and an Administrative Assistant I were in Room 7 when a loud crash was heard. Observed were two folding chairs that had been propped behind the open entry door to Room 7 and subsequently fell forward, crashing to the floor and pushing the entry door shut. This had the possibility of the door and/or chairs hitting the two residents living in Room 7 and/or any visitors that may have been in the way and causing injury to them. Admin Assist I stated the chairs should not have been left behind the door, because they could have caused an accident.	F 253	E. This code regulation correction for this regulation shall be on September 15, 2011. F253 A. The sliding glass door tracts in rooms 30 to 33 were cleaned from any thick black layer of dirt, dried leaves and cigarette butts. The broken window sill was replaced with a new sill on 8/31/11.The chairs were removed from behind the door in room 7 so as to prevent chairs from falling. B. All sliding glass door tracts were checked throughout the building ensuring that the door tracts were clean and free of debris. All window sills throughout the facility were checked and replaced as needed. Any chairs that were stored behind the doors were removed to a safe location. Staff will be re-trained on using the proper maintenance work orders system to alert maintenance of any needed repairs in the patient rooms.	9/15/11
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 4 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed accurately assess one resident upon return to the facility after three dialysis treatments (a removal of toxins from the blood when the kidneys fail to function) in a sample size of 20 residents. (Resident 17) That had the potential for changes in Resident 17's condition to go untreated. Findings: On 8/8/11, Resident 17 was admitted to the	F 278	C. Housekeeping and maintenance staff will be in-service on checking the cleanliness and sanitation of the tracks. These tracts will be cleaned monthly as part of the deep cleaning for each room. Deep cleaning is done once per month. D. There will be weekly rounds done by the maintenance supervisor ensuring that the tracts are routinely cleaned providing safe and sanitary conditions for the resident. This will be reflected in the maintenance work order system. The maintenance staff will check the window sills for unreasonable wear and tear and replace accordingly. The safety team shall make rounds and check to see if any chairs are stored behind the resident room doors. The chairs shall be moved to a safe place. Any deviations to the compliance of this code shall be reported to the QAAC for further review and action. E. The corrective date for this code shall be September 15, 2011.	9/15/11

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	555673	A. BUILDING _____ B. WING _____	09/02/2011

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F 278 Continued From page 5

facility with diagnoses that included kidney failure.

A Physician Order, dated 9/11, indicated that Resident 17 was to attend dialysis treatments at a local center every Monday, Wednesday, and Friday.

On 9/2/11, the pre and post dialysis information sheets were reviewed. Of the six visits to the dialysis center, three of the information sheets had not been completed upon Resident 17's return to the facility. This information included the time returned, vital signs, a head to toe assessment, and any changes.

During an interview on 9/2/11 at 9:30 am, Administrative Nurse (Admin) B confirmed that three of the six information assessment sheets that described Resident 17's condition upon return from the dialysis center had not been completed. Admin B added that the facility's policy had not been followed and the information sheets should have been completed.

F 314 SS=D 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced

F 278

F278

A.
The nurse for resident 17 conducted an assessment. The pre and post dialysis information sheets were completed on the next visit to the dialysis center. On 9/2/11 the post dialysis information sheets was completed.

9/5/11

B.
All residents receiving dialysis treatments were reviewed and pre and post dialysis information was completed by the licensed nurse.

F 314

C.
Nurses with care responsibilities of dialysis patients will be in serviced on completing the necessary assessments for pre and post dialysis treatments. A medical records designee shall monitor this compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 6	F 314		

by:
Based on observation, interview, and record review, the facility failed to ensure a resident having a pressure sore receive necessary treatment and services to promote healing, when Resident 2's physician order for heel protectors was not followed.

Findings:

During record review on 8/31/11, admission documentation indicated Resident 2 was admitted to the facility on 3/17/11 with diagnoses that included pressure ulcer to the right heel. The Minimum Data set (MDS-a nursing assessment tool), dated 6/26/11, indicated that Resident 2 had short and long term memory impairment and needed extensive assistance from two staff members for turning in bed and all aspects of daily living.

A physician's order, written on 4/7/11, read that Resident 2 was to have heel protectors on "at all times, every shift."

During an observation on 8/31/11 at 8:30 am, a heel protector was observed on a chair to the left of Resident 2's bed. Licensed Nurse J (LN J) lifted the blankets off the foot cradle at the end of the resident's bed, and verified there were no heel protectors on Resident 2's feet.

A physician's order had been written on 4/7/11 that read Resident 2 was to have heel protectors on "at all times, every shift."

During an interview on 8/31/11 at 8:30 am, LN J stated Resident 2 was supposed to have the heel

D.
The facility shall monitor its performance by an audit to be conducted by the medical record department. Results of the audits shall be presented to the QAAC committee for further review, recommendation and action as appropriate. 9/15/11

E.
This corrective action shall take place on September 15, 2011.

F314

A.
Resident 2 had her heel protectors put on per the physician's orders.

B.
An audit was done to ensure that all current residents that have physician orders related to specific interventions for reduction or prevention of decubitus are carried out as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 7	F 314	C. The facility has created a system that identifies specific approaches ordered by the physician for staff reference. This guide will be updated as orders change. This system will be available on both stations. The medication nurse will ensure that the orders are properly carried out and document in the MAR that the order was executed. The licensed nurse will document every shift if the protective devices are to be worn at all times. 9/15/11	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356	D. There will be an audit in the next quarter on the efficacy of the new system and reported to the QAAC for review, plan, and interventions as appropriate. The director of nurses shall monitor.	
			E. This corrective action was done On September 15, 2011.	

protector at all times.

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356	Continued From page 8 failed to post the daily staffing information. Findings: During a tour of the facility on 8/30/11 at 10:30 am, the daily staffing information was not visible. On 8/30/11 at 10:40 am, Administrative Staff E acknowledged the staffing information was not posted.	F 356	F356 9/15/11 A. The facility posted the information with the nursing hours, assignments, facility name, current date, and the total number of hours worked by registered nurses, licensed vocational nurses and certified nursing hours and resident census herein referred to as posted nurse staffing information. This will be posted in a prominent place accessible to residents and visitors and kept on file for 18 months. B. The facility will post the nurse staffing information at both nursing stations and communicate this practice to the resident council.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store food under sanitary conditions, when it did not monitor the temperature and humidity in the dry storage room of the kitchen. This had the potential to for residents to suffer from food borne illnesses. Findings: During an observation and concurrent interview on 8/30/11 at 10:35 am, there was no temperature or humidity gauge seen in the dry	F 371		

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371 Continued From page 9

storage room. Dietary Supervisor H (Admin H) confirmed that there was no thermometer and no way to check the temperature or humidity in the dry storage room.

On 8/30/11 at 11:30 am, Admin H stated that there was a temperature and humidity gauge for the dry storage room, but that it had fallen off the wall. When Admin H was asked for evidence that the temperature and humidity was checked in dry storage room, she stated that there was no evidence the room temperature and humidity was being monitored.

The undated facility policy and procedure titled, "Storage of Food and Supplies", indicated that thermometers should be placed in all storage areas and checked frequently. The recommended temperature is 50-70 degrees Farenheit.

F 386 SS=B 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS

The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the physician dated all telephone

F 371

C.
The facility will inservice the staffing coordinator and RN supervisors to post the hours by shift with date, name of facility, hours by registered nurses, licensed vocational nurses And certified nursing assistants and resident census in a conspicuous place for the public to view. In the absence of the staffing Coordinator, the RN supervisor Will post the information for The particular shift.

9/15/11

D.
The administrator or designee shall monitor the posted nurse staffing information daily. The QA process will incorporate this regulation into its process of monitoring and report any deviations for further plan and corrective action.

E.
The facility corrected this deficiency during the annual recertification survey on August 31, 2011.

F 386

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

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F 386	Continued From page 10	F 386	F371	9/15/11

and recap orders for seven of 20 sampled residents. (Residents 1, 2, 3, 7, 8, 14, and 15)

Findings:

During record review on 8/31/11 and 9/1/11, the following was discovered:

1. Resident 1's physician had signed, but failed to date two telephone orders in 8/11; four telephone orders in 7/11; and the monthly recap order sheets for 6/11, 7/11, and 8/11.

2. Resident 2's physician had signed, but failed to date five telephone orders in 8/11, and the monthly recap order sheets for 8/11 and 9/11.

3. Resident 3's physician had signed, but failed to date 13 telephone orders in 8/11 and seven telephone orders in 7/11.

4. Resident 7's physician failed to sign and date the admission orders, failed to date 16 of 16 telephone orders between 8/16/11 through 8/24/11, and four consent forms for psychotherapeutic medications.

5. Resident 8's physician failed to sign and date one psychotherapeutic medication consent form and did not date nine of 12 telephone orders between 8/19/11 through 8/25/11.

6. Resident 14's physician failed to sign and date the monthly recap order sheets for 5/11, 6/11, 7/11, and 8/11, and failed to date two telephone orders for 7/11 and 8/11.

7. Resident 15's physician had signed, but failed

A.
A temperature and
Humidifier guage was placed
On the wall immediately once
It was determined that the space
Was lacking the proper guage.
The temperature and humidifier
Guage reflected that the temp and
humidifer guage was within
normal safe limits that would not
promote food borne
illness.

B.
The other areas where dry food is
Stored will also have a guage to
Monitor temperature and
humidity.

C.
The director of dietary services or
designee shall monitor on a daily
basis the temperature and
humidity ensuring that the storage
areas are within
reasonable limits. Staff will be
inserviced on proper temperatures
and humidity levels so as to avoid
food borne illness.

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 386 Continued From page 11
to date 13 of 13 telephone orders from 8/16/11 through 8/31/11.

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 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

F 386

D.
Rounds will be done daily to ensure that the temperature of the storage area is within 50 to 70 degrees. This regulation will be a part of the quality assurance and assessment program and deviations from acceptable temps will be forwarded to QAAC for plans and action. Results of the monitoring will be done for the next 3 months. Director of dietary Services to monitor.

F 441 9/15/11

E.
The temperature and guage was replaced on August 30, 2011.

F386

A.
Resident's 1,2,3,7,8,14, and 15 all were reviewed by the attending physician. The telephone orders and monthly recap order sheets were audited to ensure that there were dates and signatures by the attending physician.

9/15/11

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary environment when an open can of carbonated energy drink was left on a medication cart during medication administration. This had the potential to contaminated the residents' medications. Findings: During an observation on 9/1/11 at 10:30 am, an open can of energy drink was on top of a medication cart, while the nurse was making medication administration rounds. During an interview on 9/1/11 at 10:35 am, Licensed Nurse D stated that the can of energy drink belonged to him, and that he should not have had it on the medication cart. On 9/1/11 at 10:40 am, Admin B stated her expectation was that nurses should not have open containers of liquids for personal consumption on the medication carts.	F 441	B. All current medical records were reviewed and checked to ensure the attending physician signed and dated the telephone orders and monthly recap orders sheets. C. Medical records designee shall inform the physicians of the need to sign and date both telephone orders and monthly recap orders. The medical records designee shall audit the attending physician signatures monthly. D. An audit system will be in place to verify physician signatures monthly. The medical director will write a memo to any physician that is deficient in this code requirement. The results of the audit shall be forwarded to the QAAC for further review, plan, and interventions as appropriate. E. This corrective action shall be in place by September 15, 2011.	9/15/11
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.	F 514		

17

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F 514	Continued From page 13	F 514		

The clinical record must contain sufficient 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 maintain a complete clinical record for one resident, after the responsible party was informed of a change in dosage of a psychotropic medication (a mood or behavior altering drug), in a sample size of 20. Resident 4)

Findings:

On 4/25/06, Resident 4 was admitted with diagnoses that included advanced Alzheimer's dementia. Resident 4's responsible party had given informed consent on 4/23/08 for "Depakote 125 milligrams twice a day," an anti-seizure medicine used to treat aggressive behavior.

On 1/31/11, a Physician's Order was written to give Depakote 500 milligrams twice a day (four times the previous order) to Resident 4. There was no written evidence that the responsible party had been notified or given informed consent when the dose had greatly increased.

On 8/30/11 at 4:30 pm during an interview, Administrative Nurse B confirmed that the informed consent had not reflected that Resident 4's responsible party had been notified, when the

F441

A.
The energy drink that was on the medication cart removed immediately once the evaluator nurse addressed the issue with the licensed staff. Medications were sealed and not exposed to the open container.

9/15/11

B.
All medications carts in the facility were checked to ensure that there were no open soda cans or personal drinking items were exposed to medications.

C.
The infection control nurse shall do rounds daily ensuring that no personal drinking means is exposed to medications. The director of nursing shall conduct an inservice to all licensed staff.

17

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F 514	Continued From page 14 Depakote was increased on 1/31/11.	F 514	D. The director of nursing shall monitor compliance of this code requirement on rounds as will the infection control nurse. Report of compliance to this code shall be forwarded to the QAAC after three months determining the efficacy of the interventions of education and daily monitoring. E. This code compliance shall be done on September 15, 2011.	9/15/11

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F 514	Continued From page 14 Depakote was increased on 1/31/11.	F 514	F514 A. The responsible party for Resident 4 signed the consent form that allowed for the 1/31/11 physician's order psychotropic medication. B. All orders for psychotropic medications that are currently being provided as ordered by the physician was audited to ensure that the consent form was in place and available for review. C. The resident that has been ordered to have a psychotropic medication will have a consent in the medical record for the medication. The physician will contact the resident and or responsible party to obtain verbal consent for its usage. The physician shall contact the nurse to communicate that such consent was obtained.	9/15/11

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F 514	Continued From page 14 Depakote was increased on 1/31/11.	F 514	D. The nurses were educated on this procedure for obtaining psychotropic restraints. The medical record designee shall monitor the consents for any psychotropic medications. Results of the audit shall be forwarded to the QAAC for further review, plan, and interventions as appropriate. E. The corrective date of completion shall be September 15, 2011.	9/15/11

17