STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555035	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK ANAHEIM HEALTHCARE CENTER	3435 W BALL ROAD ANAHEIM, CA 92804

(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 (CDPH) during a RECERTIFICATION survey. Representing the CDPH: Surveyor 33464, HFEN; Surveyor 28952, HFEN; Surveyor 34054, HFEN; Surveyor 34933, HFEN; Surveyor 35704, HFEN; Surveyor 25090, HFEN; and Surveyor 29650, HFES. The surveyors entered the facility on 7/8/15 at 1345 hours. The census was 104 with no bed holds. GLOSSARY OF ABBREVIATIONS AND BRIEF DEFINITIONS: ADON - Assistant Director of Nursing Black Box Warning - (the strongest warning that the Food and Drug Administration requires and signifies medical studies indicate the drug carries a significant risk of serious or even life-threatening adverse effects) CMS - Centers of Medicare and Medicaid Services CNA - Certified Nurse Assistant CPAP machine - continuous positive airway pressure (a treatment that uses mild air pressure to keep the airway open) CVA - cerebral vascular accident (a stroke; damage to the brain from interruption of its blood supply) Dementia - loss of mental function such as thinking, memory, and reasoning skills Diabetes mellitus - a chronic condition causing abnormally high blood sugar levels DME - durable medical equipment	F 000	Park Anaheim Healthcare Center makes its best efforts to operate in full compliance with both Federal and State regulations. Nothing included in this plan of correction is an admission otherwise. Park Anaheim Healthcare Center has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objection to the merit or form of allegation contained herein. The submission of this plan of correction constitutes our allegation for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/7/15

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

8/12/15 Accepted CS.

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F 000	Continued From page 1 DON - Director of Nursing DSD - Director of Staff Development DSS - Dietary Services Supervisor ESRD - end stage renal disease (loss of kidney function) Freedom splint - a padded, non-rigid tubular arm splint with multiple Velcro closures that restrict arm movement at the elbow Gastroesophageal reflux disease - a digestive disease in which stomach acid or bile irritates the food pipe lining Gerichair - a reclining chair with wheels that allows a patient be able to sit comfortably in a variety of positions GT - gastrostomy tube (a tube placed through the abdominal wall into the stomach, used for feeding and/or administering medications) Hepatic failure - liver failure H&P - History and Physical IDT - Interdisciplinary Team L&C Program - Licensing and Certification Program LVN - Licensed Vocational Nurse Manic state - an abnormally elevated mood state characterized by such symptoms as inappropriate elation, increased irritability, severe insomnia, grandiose notions, increased speed and/or volume of speech, disconnected and racing thoughts, increased sexual desire, markedly increased energy and activity level, poor judgment, and inappropriate social behavior MAR - Medication Administration Record MDS - Minimum Data Set (a standardized assessment tool) mg - milligram(s) Nephrologist - a medical doctor who specializes in kidney care Orthostatic hypotension - a condition characterized by a decrease in blood pressure	F 000		

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F 000	Continued From page 2	F 000		

when an individual changes position quickly, such as lying to sitting or sitting to standing quickly, often causing a feeling of dizziness or lightheadedness
OT - Occupational Therapist
Pancreatitis - inflammation of the pancreas
P&P - Policy and Procedure
PASARR - Pre-Admission Screening and Resident Review Program
POC - Plan of Correction
PT - Physical Therapist
QA - Quality Assurance
Psychotherapeutic or psychotropic medications - any medications capable of affecting the mind, emotions, and behaviors
RN - Registered Nurse
RD - Registered Dietician
RT - Respiratory Therapist
Schizophrenia - a disorder in which people interpret reality abnormally
Sliding scale insulin therapy - the dose of insulin is based on the sugar level; the higher the blood sugar, the higher the dose of insulin administered
SNF - Skilled Nursing Facility
SQ - subcutaneous (under the skin)
Suprapubic catheter - a urine drainage catheter which is inserted through the abdomen and into the bladder so urine can be drained out
Tracheostomy - a surgical procedure to create an opening through the neck into the trachea (windpipe); a tube is usually placed through this opening to provide an airway and to remove secretions from the lungs
Ventilator - a machine designed to mechanically move breathable air into and out of the lungs to provide the mechanism of breathing for a patient who is physically unable to breathe, or breathe sufficiently

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

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 226 F 226 SS=D	Continued From page 3 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and facility P&P review, the facility failed to ensure one staff member (RN 5) was aware of the procedures to take when there was an allegation of abuse against an employee and failed to follow their abuse P&P for reporting allegations of abuse to the CDPH, L&C Program. This posed the risk of not protecting all residents from possible abuse. Findings: 1. During the entrance conference on 7/8/15 at 1400 hours, the Administrator identified himself as the facility's Abuse Coordinator. Review of the facility's P&P titled Abuse and Mistreatment of Residents (undated) showed if the suspected perpetrator is a staff member, the staff member is to be placed immediately under administrative suspension for three days or more, depending upon the resolution and/or conclusion of the alleged violations. During an interview on 7/8/15 at 1610 hours, RN 5 was asked what he would do if there was an allegation of abuse against a staff member. RN 5 stated he would conduct an investigation and	F 226 F 226	F 226 RN5 was immediately in-serviced and retrained by the Administrator with the collaboration of DSD on P&P Abuse Allegation, Investigation, and Reporting. A follow up letter with a conclusion of the investigation on 12/20/2014 was sent to the Department of Health Services immediately by the Administrator. On 07/14/2015, the Administrator and the Director of Nursing reviewed all abuse allegation investigations from previous recertification survey to present to ensure each allegation was thoroughly investigated. No abuse allegation investigations were identified with the same deficient practice. An in-service was initiated by the Administrator to all staff on 07/14/2015 and was completed on 07/30/2015 regarding P&P on Abuse Allegation, Investigation, and Reporting. All abuse investigations will be reviewed by the Administrator and DON to ensure completeness of documentation including a follow up letter to DHS with conclusion.	07/14/2015 07/23/2015 07/14/2015 07/30/2015

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

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F 226	Continued From page 4 confront the staff member in private. He added if the allegation was true or not, he would teach and re-educate the staff member. RN 5 stated he would ask the staff member to apologize to the resident and assign the staff member to another resident. RN 5 was asked who their Abuse Coordinator was. RN 5 stated the DON. During an interview with the Administrator on 7/10/15 at 0900 hours, regarding the facility's abuse policies, the Administrator was asked if there was any circumstances in which an employee with an allegation of abusing a resident would be allowed to continue providing care to the residents. The Administrator stated there was no scenario wherein a staff member would be allowed to care for other residents after an allegation of abuse; the staff member would be sent home pending the outcome of the investigation. 2. Review of the facility's P&P titled Abuse Allegation Investigation (undated) showed the Administrator will notify the Department of Health Services of the conclusion of the investigation within five working days and include what appropriate actions were and/or will be taken. On 7/10/15 at 0900 hours, an interview regarding the facility's abuse P&P and a concurrent review of two abuse investigations was conducted with the Administrator. Review of the documents of an investigation conducted regarding resident to resident abuse dated 12/30/14, failed to show the facility notified the CDPH(formerly called the Department of Health Services), L&C Program of the conclusion of their investigation. When asked, the Administrator verified the facility failed to notify the CDPH, L&C Program as required.	F 226	An Abuse P&P re-training will be held quarterly and as needed by the Administrator in collaboration with the DSD. The Administrator and DON will review all abuse investigations monthly to ensure facility's P&P was followed. Findings will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	

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F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, the facility failed to provide an individualized activities program to meet the identified physical, mental, and psychosocial needs of two of 21 sampled residents (Residents 1 and 3). This created the risk of not maintaining the highest practicable level of well-being for these residents. Findings: 1. During the facility's initial tour with RN 2 on 7/8/15 at 1440 hours, Resident 3 was observed in bed, awake. Resident 3 was observed with a tracheostomy tube and on a ventilator. Clinical record review for Resident 3 was initiated on 7/9/15. The MDS dated 3/9/15, showed the resident had short-term and long-term memory problems. Review of the physician's order dated 4/9/15, showed to transfer the resident out of bed into a gerichair to attend the activity program. The Activity Progress Notes dated 6/8/15, showed the resident's current activity preferences were cards, exercise, religion, watching TV, social with	F 248	F 248 Upon notification, Resident 1 and 3's Care Plans were immediately revised by the Activity Director to include out of the room activity program at least twice weekly. The Activity Director conducted a care plan review on 07/24/2015 of all SAU residents. Out of 40 residents in SAU, no other residents were identified with the same deficient practice. In-service was conducted by Director of Nursing on 07/24/2015 to Nursing and Activity staff regarding SAU residents participating twice weekly in planned activities including out of bed or out of room if not contraindicated with residents plan of care and medical condition. Activity Care Plans must be individualized based on activity preferences and needs. The Activity Director immediately updated attendance log to indicate that residents in SAU attended the group activity program as ordered. The Medical Records Designee will audit all admissions to ensure care plans are completed within 72 hours. The audits and activity attendance will be reviewed, verified, and will be signed by the DON and Activity Director monthly. Findings will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	07/24/2015 07/24/2015 07/24/2015

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F 248	Continued From page 6 staff, and sensory stimulation. Review of Resident 3's plan of care showed a care plan problem dated 3/1/15, to address the resident's risk for self-isolation and lack of environmental stimulation. The care plan interventions included to provide in-room activities such as hand massage, aroma therapy, and audio books. However, the care plan interventions did not include out of room or out of bed activity programs. On 7/9/15 at 0730, 1040, and 1515 hours, Resident 3 was observed in bed. Further review of the Activity Participation Record for Resident 3 for the months of March, April, May, and June 2015 showed room visits were provided; however, there was no documented evidence Resident 3 had attended a group activity program. During an interview with CNA 2 on 7/13/15 at 0705 hours, CNA 2 stated Resident 3 could respond by nodding. CNA 2 was asked if he transferred Resident 3 in a gerichair. He replied after he showered the resident, he put him in a gerichair and wheeled the resident next to the nurses' station. He was asked if he took the resident to the group activity program. He replied he could. 2. During the facility's initial tour with RN 2 on 7/8/15 at 1440 hours, Resident 1 was observed in bed, awake. Resident 1 was observed with a tracheostomy tube and on a ventilator. Clinical record review for Resident 1 was initiated on 7/8/15. The MDS dated 4/22/15, showed the	F 248		

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F 248	Continued From page 7 resident had short-term and long-term memory problems. Review of the physician's order dated 6/26/15, showed to transfer the resident out of bed into a gerichair to attend the activity program. Review of Resident 1's plan of care showed a care plan problem dated 6/30/15, to address the risk for self-isolation and lack of environmental stimulation. The care plan interventions included to provide in-room activities such as hand massage, aroma therapy, and audio books. However, the care plan interventions did not include out of room or out of bed activity programs. Review of the Activity Participation Record for Resident 1 for the month of July 2015 showed room visits were provided; however, there was no documented evidence Resident 3 had attended a group activity program. During an interview with CNA 4 on 7/13/15 at 0840 hours, CNA 4 was asked if he got Resident 1 up to attend group activities. CNA 4 stated after he provided a shower to the resident, he put the resident in a gerichair. An interview was conducted with RT 1 on 7/13/15 at 1045 hours. RT 1 was asked if residents on ventilators could attend group activities. He replied yes, the residents could take the ventilator with them and he could be there to monitor them. On 7/13/15 at 1050 hours, Resident 1 was observed in a gerichair; however, Resident 1 was placed next to his room.	F 248		

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F 248	Continued From page 8 An interview with the Activity Director was conducted on 7/13/15 at 1055 hours. When asked what activity program they provided for Residents 1 and 3, the Activity Director stated they encouraged the residents to attend the group activity program at least three times a month. He was asked if Residents 1 and 3 had attended a group activity program. He replied yes. He was asked if they had an attendance record for the group activity program. He stated Resident 1 and 3's activity attendance wound be in the clinical record. He reviewed the clinical records and acknowledged there was no documented evidence to show Residents 1 and 3 had attended a group activity program. He was informed the residents' plans of care did not include interventions for out of bed or out of room activities. He reviewed the residents' plans of care and acknowledged there were no interventions for out of bed or out of room activities.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F 279 Upon notification, Resident 13's care plan was immediately developed by the Registered Nurse to address resident's refusal of food after the insulin administration. Resident 13's blood sugar check was adjusted to 5:00 am to give ample time for Nursing Staff to monitor Resident before going to dialysis. The licensed nurse will communicate with dialysis center if Resident has insulin coverage and as to blood sugar reading to alert them to monitor for possible reaction.	07/09/2015

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F 279	Continued From page 9 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to ensure comprehensive care plans were developed and revised for two of 21 sampled residents (Residents 13 and 18). * Review of Resident 13's care plan failed to show a care plan problem to address the resident's refusal of food after the insulin administration. * Review of Resident 18's comprehensive care plan to address the resident's antipsychotic medication failed to include the correct indication, dose, side effects, and Black Box Warning information of the medication. These posed the potential for lack of knowledge when providing care to the resident. Findings: 1. Clinical record review was initiated for Resident 13 on 7/8/15. Resident 13 was readmitted to the facility on 4/1/15, with diagnoses including diabetes mellitus and ESRD. The resident received dialysis treatments three times a week at 0515 hours (Monday, Wednesday, and Friday) at the dialysis center.	F 279	On 07/27/2015, Resident 18's Depakote was discontinued by the Psychiatrist following IDT recommendation. The care plan was updated as resolved by the DON. The DON and the ADON reviewed all Residents on dialysis to ensure that all medications requiring monitoring have sufficient time between administration and transportation pick up. Out of three residents on dialysis, no other residents were identified with the same deficient practice. The DON and ADON reviewed all residents with anti-psychotic medications to ensure all care plans address the need and process of gradual dose reduction, medication indications, monitoring the right behavior and side effects as described in the Black Box Warning. No other residents were identified with the same deficient practice. An in service was given by the DON and ADON to all licensed nurses on 07/14/2015 and completed on 07/30/2015 completion of care plans and the importance of indicating the need and process of gradual dose reduction, medication indications, monitoring the right behavior and the side effects described in the Black Box Warning. DON conducted in-service to all licensed nurses on filling out Dialysis Communication to Dialysis Center	07/27/2015 07/14/2015 07/14/2015 07/30/2015

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F 279	Continued From page 10 Review of the physician's order dated 5/20/15, showed to check Resident 13's blood sugars three times a day before meals (breakfast, lunch, and dinner) and administer Aspart insulin (antidiabetic medication) SQ using a sliding scale. Review of the Nutritional Assessment Notes dated 4/3/15, showed Resident 13 was offered sack lunches on dialysis days; however, the resident refused. She wanted to save her breakfast tray and eat her food once she returned from her treatment. On 7/9/15 at 1115 hours, an interview and concurrent clinical record review was conducted with LVN 4 and the DON. Review of the June 2015 MAR showed to check Resident 13's blood sugars three times a day before meals (at 0630, 1130, and 1630 hours) and at bedtime (at 2100 hours) and administer Aspart insulin per the insulin sliding scale. The nursing staff documented they had been administering Aspart insulin at 0630 hours; however, the resident was scheduled to leave the facility between 0500 to 0530 hours on the days she received dialysis treatments at the dialysis center. The DON was asked who monitored the resident after the administration of the insulin. The DON stated the resident went to the dialysis center. LVN 4 was asked if the resident was provided a sack lunch before she left for her dialysis treatments. LVN 4 stated Resident 13 took her own food to the dialysis center. On 7/13/15 at 1046 hours, an interview was conducted with Resident 13. The resident confirmed she went to dialysis three times a week around 0500 hours and return to the facility around 0900 hours. The resident was asked if	F 279	The DON/ADON will review all care plans for completeness and appropriateness of all new admissions, significant changes and change of conditions daily during clinical meetings. All findings will be corrected immediately and will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	

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F 279	Continued From page 11 the facility sent her with food to the dialysis center. She stated she did not take food to the dialysis center because nobody ate at the dialysis center. She added she always ate her breakfast in the facility when she returned from her dialysis treatments. Review of Resident 13's plan of care failed to show a care plan problem to address the refusal of food after the morning insulin administration which was prior to going to the dialysis center between 0500 to 0530 hours. An interview and concurrent clinical record review was conducted with the DON on 7/13/15 at 0929 hours. When asked if there was a care plan problem developed to address Resident 13's refusal of food after the morning insulin administration which was prior to going the dialysis center, the DON stated the licensed staff developed the care plan problem addressing the resident's refusal to take food on 7/9/15. Cross reference to F309. 2. Clinical record review for Resident 18 was initiated on 7/10/15. Resident 18's clinical record showed the resident was admitted on 2/24/15. Resident 18's H&P dated 2/25/15, showed diagnoses of schizophrenia and dementia. Review of Resident 18's physician's orders dated 6/18/15, showed to administer Depakote ER (an anticonvulsant medication in an extended release form, sometimes used as an antipsychotic medication) 250 mg one tablet by mouth once a day for manic disorder manifested by persistent agitation/restlessness. A physician's orders dated 2/24/15, showed to monitor the resident for	F 279		

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PARK ANAHEIM HEALTHCARE CENTER	3435 W BALL ROAD ANAHEIM, CA 92804

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F 279	Continued From page 12 cognitive impairment, Parkinsonism syndrome, orthostatic hypotension, akathisia, and tardive dyskinesia. According to Lexi-Comp Online, Depakote ER carries a Black Box Warning for hepatic failure, resulting in fatalities and severe pancreatitis. Lexi-Comp further showed liver function tests should be performed at regular intervals following initiation of therapy with Depakote ER. Monitor patients closely for appearance of malaise, weakness, facial edema, jaundice, and promptly evaluate symptoms of abdominal pain, nausea, vomiting, and/or anorexia. Review of Resident 18's comprehensive care plan dated 2/24/15, and revised on 4/2/15, showed a problem to address periods of anxiety manifested by persistent agitation/restless, medication: Depakote ER. The documented goal was to minimize the risk of adverse side effects of the medication and reduce the episodes of anxiousness. The interventions showed to observe for and document occurrence of side effects, and listed the side effects as sedation drowsiness, morning hangover, and ataxia. The care plan problem failed to address monitoring of the resident for the adverse effects ordered by Resident 18's physician. The care plan problem failed to address the adverse effects described in the Black Box Warning for Depakote ER. The care plan failed to show the prescribed dose of Depakote ER or the dose reduction ordered on 6/18/15. Additionally, the care plan problem showed Resident 18's indication for the Depakote ER was anxiety. However, the indication for Resident 18's Depakote ER was manic state.	F 279		

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F 279	Continued From page 13 On 7/13/15 at 1130 hours, an interview was conducted with LVN 7. LVN 7 was asked to show a care plan to address Resident 18's use of Depakote ER. LVN 7 reviewed the resident's care plan and verified the above findings.	F 279		
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to ensure safe and comprehensive discharge plans were completed for three of 21 sampled residents (Residents 20, 19, and 21). * The facility failed to provide the contact information for the home health agency and information on receiving a wheelchair after discharge for Resident 20. The facility failed to clarify if Resident 20 was to continue taking the cranberry supplement at home. * Resident 19 had a diagnosis of diabetes mellitus with a physician's orders for blood sugar monitoring and the administration of insulin. However, the discharge plan of care failed to include the physician's instructions for monitoring and treating the diabetes.	F 284	F 284 Upon notification, the Social Service Director called Resident 20 to ensure he received his wheelchair and if he is taking his cranberry supplement. Resident 20 stated that he received his wheelchair and did not have any issues in contacting his home health agency. He also stated that he still takes his cranberry supplement daily. The Social Service Director had verified with Hospice Services that they monitored and gave instructions to Resident 19 and to her family regarding her diabetes mellitus. The Social Service Director contacted Resident 21 to ensure if he have any issues in contacting his home health agency. Resident 21 stated that he did not have any problems as contact information was provided in discharge packet given at discharge by Social Service Director.	07/10/2015 07/10/2015 07/10/2015

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F 284	Continued From page 14 * The facility failed to provide Resident 21 with the name and telephone number for the home health agency and DME company upon discharge. These failures had the potential for the residents/responsible parties to not have the necessary information to ensure continuity of care, prevention of medication mistakes, and follow up of medical care. Findings: 1. Closed clinical record review for Resident 20 was initiated on 7/10/15. Resident 20 was admitted to the facility on 4/3/15, and discharged on 5/1/15. a. Review of the physician's orders dated 4/28/15, for Resident 20 showed home health agency follow up to provide PT/RN and DME for a wheelchair to assist the resident after discharge. However, review of the Post Discharge Plan of Care form dated 5/1/15, showed a section on the form where staff were to list the name, address, and telephone number for the home health agency were left blank. b. Review of the medication orders dated 4/15 for Resident 20 showed an order for cranberry 450 mg two capsules every day. Review of the Post Discharge Plan of Care form dated 5/1/15, showed a section for medications to continue at home, but the cranberry supplement was not listed. On 7/13/15 at 0820 hours, a concurrent closed clinical record review and interview was conducted with the DON. The DON verified	F 284	The Medical Records Designee conducted an audit for completeness of discharge forms of all residents discharged in the past 90 days to a lower level of care or home to ensure all post discharge plan of care documentation is complete. No other resident were affected with the same deficient practice. An in-service was given by the DON to all licensed nurses on 07/14/2015 and was completed on 07/31/2015 regarding completion of post discharge plan of care documentation. The Social Service Designee will continue to provide discharge packets containing contact information for home health and DME providers and other community resources to all residents discharging to lower level of care or home. This will be documented by the Social Service Designee on the Additional Discharge Planning Notes section of Post Discharge Plan of Care. The RN Supervisor will review all post discharge plan of care documentation before signing for completion. All discharges will be reviewed by the DON to be reported and tracked at our QA Committee Quarterly for evaluation and further action.	07/27/2015 07/31/2015

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F 284	Continued From page 15 Resident 20 was to receive home health services and a wheelchair after discharge, but the Post Discharge Plan Of Care form did not list the name, address, or telephone number of the home health agency in the space provided. The DON verified the cranberry 450 mg, take two capsules everyday was missing on the Post Discharge Plan Of Care form. 2. On 7/10/15, closed clinical record review was initiated for Resident 19. Resident 19 was admitted to the facility on 3/6/15, and discharged to home with hospice services on 4/16/15. Resident 19's admitting diagnoses included diabetes mellitus. Review of Resident 19's active medication orders at the time of discharge included fingerstick blood sugar monitoring before breakfast and bedtime, with insulin sliding scale coverage. Review of the physician's orders dated 4/14/15, showed an order to discharge the resident to home with hospice services. Review of the Post Discharge Plan of Care form dated 4/16/15, showed the medications to be taken at home but did not include the blood sugar monitoring or insulin administration. During an interview and concurrent closed clinical record review with the DON on 7/13/15 at 0900 hours, she reviewed the closed clinical record for Resident 19 and was unable to find documentation of why the blood sugar monitoring and insulin administration were not included in the post discharge plan of care.	F 284		

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F 284	Continued From page 16 3. Closed clinical record review for Resident 21 was initiated on 7/10/15. The clinical record showed Resident 18 was admitted to the facility 3/12/15, with diagnoses which included obstructive sleep apnea and chronic respiratory failure. Review of Resident 18's physician's orders dated 6/10/15, showed an order to discharge the resident home on 6/16/15, with home health RN/ PT and DME for a CPAP machine. Review of Resident 21's Post Discharge Plan of Care dated 6/16/15, showed home health RN/PT and DME for a CPAP machine. However, the form failed to show the name or contact number for the home health agency or DME provider. On 7/10/15 at 1450 hours, an interview and concurrent closed clinical record review was conducted with the DON. The DON verified the findings and stated the name and contact information for the home health agency and DME provider should have been provided to Resident 21.	F 284		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health	F 285	F 285 Upon notification, Resident 14's Level II PAS/PASRR was transmitted by the Business Office Manager via facsimile to California Department of Health Care Services – Mental Health Services Division immediately and was completed online by the ADON on 07/16/2015.	07/16/2015

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F 285	Continued From page 17 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to make a Level II PAS/PASARR referral for one of 21 sampled residents (Resident 14). Failure to complete the referral had the	F 285	The Business Office Manager completed an audit on all admissions from the past six months to ensure all PAS/PASRR screening document are completed and transmitted. No other resident were affected with the same deficient practice. An in-service was given by the DON to all Registered Nurses on 07/14/2015 and was completed on 07/31/2015 regarding proper completion of PAS/PASRR screening document upon admission. MDS Coordinator is responsible for online transmission of PAS/PASR and it will be coordinated by the Business Office Manager. Business Office Manager will keep a log of all PAS/PASRR Level I screening documents and completed Level II referrals. The Administrator will review PAS/PASRR log of all admissions for the month to ensure coordination of PAS/PASRR completion and transmission. Findings will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	07/27/2015 07/31/2015

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F 285	Continued From page 18 potential to delay the resident's appropriate treatment for mental illness. Findings: Clinical record review for Resident 14 was initiated on 7/9/15. Resident 14 was admitted to the facility on 4/30/15. Review of the PAS/PASARR Screening Document dated 4/30/15, showed a referral to the DMH (Department of Mental Health) was required for a mental illness diagnosis. The Level II completion box on the form was blank. Resident 14 had identifying criteria for mental illness of schizophrenia. During an interview with RN 1 on 7/10/15 at 0840 hours, she was asked about the facility's practice for PAS/PASARR referrals. She stated a Level II PAS/PASARR referral would be processed by the business office. RN 1 reviewed the clinical record for Resident 14 and stated the NCR (no copy required) part of the form the business office needed to process remained in the clinical record and had not been given to them. During an interview with the Business Office Manager on 7/10/15 at 1040 hours, she was unable to find documentation of a referral to the DMH for Resident 14. Review of the facility's P&P titled PASARR Completion dated 3/10/15, showed only Level I completion. The policy did not address how referrals were processed for Level II PAS/PASARR referrals and did not address department responsibility for the referrals.	F 285		

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F 309 F 309 SS=D	Continued From page 19 483.25 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, clinical record review, and interview, the facility failed to provide the necessary care and services to one of 21 sampled residents (Resident 13) to ensure the resident maintained the highest physical, mental, and psychosocial well-being. * Resident 13 received dialysis treatments (a process to remove waste and excess water from the blood due to failing kidney function) at the dialysis center. The licensed nurses failed to coordinate care between the facility and dialysis center, which had the potential for caregivers not knowing when the resident received medications and treatments. Failure to communicate could have a detrimental effect on the resident's medical condition. Findings: According to the U.S. National Library of Medicine, Aspart insulin is a fast-acting type of insulin and should be administered 5 to 10 minutes before a meal. Insulin is one of many hormones that helps the body turns the food into	F 309 F 309	F 309 Upon notification, the DON immediately conducted an in-service to all licensed nurses regarding coordination of care between facility and dialysis center. For the meantime, the Registered Nurse, with the physician's approval, amended the order for Resident 13's blood sugar checked at an earlier time to give licensed nurses time to monitor resident after the administration of Aspart insulin. The DON and ADON reviewed all residents on dialysis to ensure proper coordination of care between facility and dialysis center. No other residents were affected with the same deficient practice. On 07/17/2015, the DON spoke to Resident 13 regarding changing dialysis schedule to a later time. Resident 13 agreed to change but dialysis center has no open slots later in the day, dialysis center will coordinate with the facility once a later schedule becomes available. Effective Friday, 08/07/2015, the Dialysis Center informed us that the blood sugar check on Resident 13's dialysis days will be done at the center and post insulin administration which will be communicated to the facility. An in-service was given by the DON to all licensed nurses on 07/14/2015 and was completed on 07/31/2014 regarding coordination of care between facility and dialysis center. DON also in-serviced all licensed nurses regarding developing care plans for non-compliant residents with interventions as needed.	07/13/2015 07/14/2015 08/04/2015 07/31/2015

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F 309	Continued From page 20 energy. Clinical record review for Resident 13 was initiated on 7/8/15. Resident 13 was readmitted to the facility on 4/1/15, with diagnoses including diabetes mellitus and ESRD. Review of the MDS dated 2/26/15, showed Resident 13 was cognitively intact. Review of the physician's order dated 4/1/15, showed an order for hemodialysis treatments three times a week at 0515 hours (Monday, Wednesday, and Friday) at the dialysis center. Review of the physician's order dated 5/20/15, showed to check Resident 13's blood sugars three times a day before meals (breakfast, lunch, and dinner) and administer Aspart insulin SQ per the insulin sliding scale. An interview was conducted with LVN 4 on 7/9/15 at 1112 hours. LVN 4 stated Resident 13 went to the dialysis center three times a week and left the facility between 0500 to 0530 hours until 0900 to 0930 hours. On 7/9/15 at 1115 hours, an interview and concurrent clinical record review was conducted with LVN 4 and the DON. Review of the June 2015 MAR showed to check Resident 13's blood sugars three times a day before meals (at 0630, 1130, and 1630 hours) and at bedtime (at 2100 hours) and administer Aspart insulin per the insulin sliding scale. The nursing staff documented they had been administering Aspart insulin at 0630 hours; however, the resident left the facility between 0500 to 0530 hours on her dialysis treatment days. The DON was asked	F 309	The DON/ADON will conduct a weekly audit to ensure all dialysis resident's care were coordinated with dialysis center. All audits will be reviewed by the DON and will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	

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F 309	Continued From page 21 who monitored the resident after the administration of the Aspart insulin. The DON stated the resident went to the dialysis center. LVN 4 was asked if the resident was provided with a sack lunch before she went to dialysis. LVN 4 stated Resident 13 took her own food to the dialysis center. Review of the Nutritional Assessment Note dated 4/3/15, showed Resident 13 was offered sack lunches on dialysis days; however, the resident refused to take the sack of food. She wanted to save her breakfast tray and eat her food once she returned from her dialysis treatments. On 7/13/15 at 1046 hours, an interview was conducted with Resident 13. The resident confirmed she went to dialysis three times a week around 0500 hours, and returned to the facility around 0900 hours. The resident was asked if the facility sent food with her to the dialysis center. She stated she did not take food with her to the dialysis center because nobody ate in the dialysis center. She stated she always ate her breakfast in the facility when she returned from her dialysis treatments. Further review of the clinical record was conducted with LVN 4 on 7/9/15 at 1605 hours. Review of the Dialysis Communication Records dated from 6/1/15 to 7/8/15, did not show any documentation the licensed nurses were documenting the blood sugar results and the Aspart insulin was administered to the resident prior to leaving for her dialysis treatments. LVN 4 verified the finding and stated the blood sugar results and the insulin administration should be written on the communication form to alert the dialysis center. LVN 4 was asked how many	F 309		

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F 309	Continued From page 22 minutes the food should be served to the resident after the administration of the Aspart insulin. She stated the food should be given within 30 minutes. Review of the Multidisciplinary Progress Record dated 6/1/15 to 7/8/15, showed the licensed nurses documented Resident 13's departure from the facility varied from 0500 hours to 0530 hours. There was no documentation the licensed nurses notified the dialysis center regarding Resident 13's refusal of sack lunches and to monitor the resident's blood sugars after the administration of insulin. A telephone interview was conducted with the Dialysis Nurse at the dialysis center on 7/9/15 at 1510 hours. He was asked if they had been notified by the facility regarding Resident 13's refusal to take a sack lunch after administration of the Aspart insulin on her dialysis days. The Dialysis Nurse was also asked if there was documentation showing they were notified of Resident 13's blood sugars and the amount of insulin received prior to leaving for her dialysis treatments. The Dialysis Nurse stated he reviewed the clinical record of Resident 13 and there was no documentation found they were notified by the facility of any blood sugar results or any Aspart insulin administered to the resident prior to dialysis treatments. He stated they were not notified Resident 13 had been refusing food after her insulin administration. The Dialysis Nurse was asked if they monitored Resident 13's blood sugars in the dialysis center. He stated only if the resident was symptomatic and if there was an order from the dialysis center's physician. There was no documented evidence the staff	F 309		

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F 309	Continued From page 23 contacted the physician and attempted to adjust the schedule of dialysis treatments or the schedule of morning insulin dose medication. On 7/13/15 at 0929 hours, the above concerns were reviewed with the DON. The DON verified the above findings and stated Resident 13's blood sugars and the Aspart insulin administered to the resident should have been written on the dialysis communication forms. She stated the facility should have notified the dialysis center to monitor Resident 13's blood sugars due to her refusal of food after the insulin administration. A telephone interview was conducted with Physician 1 on 7/13/15 at 1149 hours. Physician 1 was asked if the facility notified him regarding Resident 13's refusal to take her sack lunches after receiving the Aspart insulin and the resident was getting the Aspart insulin at 0500 hours instead of 0630 hours and being sent out to the dialysis center. Physician 1 stated he was notified by the facility; however, he could not remember the date. He stated he already talked to the resident's nephrologist to change the schedule of her dialysis treatments.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 Upon notification, Maintenance Supervisor removed gerichair from use on floor. Resident A was assessed by RN 6 immediately for any skin issues. No skin tears located. Upon notification, Maintenance Supervisor secured electric fan in room E and refrigerator in room D.	07/10/2015

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F 323	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to identify accident hazards for one nonsampled resident (Resident A). In addition, unsecured items were observed in two other rooms (Rooms D and E). * A damaged gerichair was being utilized to transport Resident A. * The facility failed to secure one portable electric fan in Room E. * An unsecured refrigerator was placed on a file cabinet in Room D. These unsecured items created a potential for serious injuries to the residents. Findings: 1. During an observation on 7/10/15 at 1310 hours, a damaged gerichair was observed in the shower room. The chair had Resident A's name on the seat back. The chair had 6 inches of plastic protruding inward towards the seat of the chair on the right, and a broken arm rest with red tape on the left. The left arm was missing an end cap and had a jagged metal edge. During an interview with CNA 5 on 7/10/15 at 1310 hours, CNA 5 stated Resident A was transported to the shower room in the identified gerichair on 7/8/15, and stated she did not notice it was broken at that time. On 7/10/15 at 1310 hours, RN 1 and the Maintenance Supervisor identified the broken	F 323	The Maintenance Supervisor completed room rounds on 07/10/2015 of all rooms and evaluated all facility equipment, including resident's appliances. No other residents were affected with the same deficient practice. An in-service was given by the Administrator with the collaboration of the Maintenance Supervisor 90% of all staff on 07/14/2015 and was completed on 07/31/2015 regarding reporting the use of Maintenance Log to report potential accident hazards to Maintenance Supervisor. Maintenance Supervisor to complete room rounds daily to ensure resident environment remains free of accident hazards and check Maintenance Log each shift. RN Supervisor to report to the Maintenance Supervisor for hazards that require immediate attention. Administrator to review Maintenance Log monthly with Maintenance Supervisor to ensure completion and identify patterns of potential hazards. All findings will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	07/10/2015 07/31/2015

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F 323	Continued From page 25 chair as hazards and removed it from the shower room. When asked if this was the facility's equipment or the resident's personal equipment, RN 1 stated the chair belonged to the facility. On 7/10/15 at 1430 hours, RN 6 stated she completed a skin assessment on Resident A at 0930 hours and did not identify any skin tears. 2. On 7/8/15 at 1352 hours, a tour of the facility was conducted with RN 1. A portable electric fan was observed on top of the shelf in Room E. The portable electric fan was not secured to the wall. RN 1 verified the finding and stated maintenance staff needed to be notified. 3. During the initial tour on 7/8/15 at 1415 hours, an unsecured resident refrigerator was observed on top of a small two drawer file cabinet in Room D. On 7/13/15 at 1000 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor in room D. He verified the refrigerator was shaky and could easily fall over if pushed.	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 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.	F 329	F 329 The DON and ADON immediately in-serviced all licensed nurses on duty regarding consistently monitoring behavior of residents with anti-anxiety medication.	07/08/2015

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F 329	Continued From page 26 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 observation, interview, clinical record review, and facility P&P review, the facility failed to ensure three of 21 sampled residents (Residents 1, 18, and 14) were free from unnecessary medications. * The facility failed to re-evaluate the administration of an antianxiety medication routinely in conjunction with a physical restraint to control Resident 1's behavior of attempting to pull out the tracheostomy tube. In addition, the facility failed to accurately monitor the target behavior for the use of an antianxiety medication and adequately monitor for side effects of the medication as ordered by the physician. * The facility failed to identify appropriate behavior manifestations for the use of Depakote for Resident 18 and failed to monitor the resident's liver function.	F 329	Resident 1's monitoring for Ativan side effects were immediately started by assessing for orthostatic hypotension. Resident 1's orthostatic hypotension will be monitored starting 07/14/2015 initially every 12 hours for 14 days, then weekly on Wednesdays. On 07/14/2015, Resident 1's Psychotropic Summary for June 2015 was completed by the licensed nurse. Per physician's order, Resident 18's liver function test was obtained on 07/14/2015. Result returned normal level that was relayed to physician with no new order. Resident 14's Tylenol pain medication was continued and it will be given prior to rehab and wound treatment. Resident admitted with Stage III pressure ulcer on left foot DON reviewed all residents on pain medication for proper indication and if residents are assessed for pain prior to administration; reviewed all residents on psychotropic medication to ensure behaviors are consistently monitored, to ensure residents are monitored for liver function, and to ensure residents are monitored for orthostatic hypotension. No other residents were affected with the same deficient practice. An in-service was given to all licensed nurses by the DON/ADON on 07/14/2015 and was completed on 07/31/2015 regarding monitoring of residents on psychotropic medications for consistency	07/14/2015 07/14/2015 07/14/2015 07/14/2015 07/31/2015

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F 329	Continued From page 27 * Resident 14 was continuously receiving pain medication without an indication for its use. In addition, the facility failed to assess the resident's pain prior to the administration of the pain medication. These had the potential for the unnecessary use of medications and adverse side effects affecting the residents' well-being. Findings: 1. During the initial tour with RN 2 on 7/8/15 at 1440 hours, Resident 1 was observed in bed, awake. Resident 1 was observed with a tracheostomy tube, on a ventilator, and a freedom splint to the right arm. RN 2 was asked if Resident 1 was interviewable. RN 2 stated the Resident 1 was non-verbal. RN 2 was asked if the resident had family members who visited. RN 2 replied no. Clinical record review for Resident 1 was initiated on 7/8/15. The resident was readmitted from the acute care hospital on 6/26/15. The MDS dated 4/22/15, showed the resident had short-term and long-term memory problems. The physician's order dated 6/26/15, showed to administer buspirone (generic name of Buspar, an antianxiety medication) 15 mg one tablet via GT every eight hours routinely for psychosis manifested by episodes of pulling out life sustaining tubes, administer Ativan (antianxiety medication) 0.5 mg one tablet via GT as needed for anxiety manifested by hitting the bed upper siderails, and monitor for side effects of the medication by assessing for orthostatic	F 329	in monitoring behavior, side effects, medication indications need and process of gradual dose reduction, and purpose of Black Box Warning. An in-service was also given by the DON/ADON to all licensed nurses regarding residents on pain medication for appropriate indication and assessing for pain prior to administration of medication. The RN Supervisor will ensure that all new psychotropic medication orders have consistent behavior monitoring and RN Supervisor will monitor during their shift that all licensed nurses assess residents on pain medication prior to administration and to ensure medication indications are appropriate. The DON/ADON will review all new psychotropic medication orders daily to ensure appropriate behaviors are monitored consistently, to ensure if medication is needed in conjunction with a physical restraints, and to ensure medication side effects are monitored. RN Supervisor will report to DON her findings in monitoring assessment of pain prior administration of medication. All finding will be reviewed and corrected by the DON and to be reported and tracked at our QA Committee Quarterly for evaluation and further action.	

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F 329	Continued From page 28 hypotension every 12 hours for 14 days, then weekly on Wednesdays. Review of Resident 1's plan of care showed a care plan problem dated 6/26/15, to address the use of hand mittens due to pulling out life sustaining tubes. The care plan interventions included to release the hand mittens, check for circulation/skin impairment, and perform range of motion. The care plan problem was revised on 6/29/15, to apply a less restrictive measure. The physician's order dated 6/29/15, showed to apply a right upper extremity freedom splint to prevent from pulling out life sustaining devices such as the tracheostomy tube and GT. Review of the MAR for the month of June 2015 showed Resident 1 did not exhibit the behaviors of pulling life sustaining tubes for the use of hand mittens, which was inconsistent with the same behavior being monitored for the use of Buspar, showing the resident had 12 episodes. Review of the 72-hour Restraint Reduction Trial Documentation for the use of a right hand mitten from 6/16/15 to 6/28/15, showed the resident had no episodes of pulling out life sustaining devices. Review of the Psychotropic Summary Sheet for Buspar showed the form was blank. Further review of the MAR for the month of June 2015 showed no documented evidence Resident 1 was assessed for orthostatic hypotension every 12 hours as ordered by the physician. The MAR for 7/1/15 to 7/12/15, showed orthostatic hypotension was assessed on 7/1 and 7/8/15, instead of every 12 hours until 7/9/15.	F 329		

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F 329	Continued From page 29 During an interview with CNA 1 on 7/9/15 at 0635 hours, she was asked if Resident 1 had episodes of pulling out his tracheostomy tube. She stated she did not witness the resident pulling out his tracheostomy tube. She further stated with the freedom splint, the resident could not pull out his tubes. An interview was conducted with LVN 5 on 7/13/15 at 0720 hours. LVN 5 was asked if the use of the freedom splint was effective in preventing Resident 1 from pulling out his tracheostomy tube. She replied yes. She further stated there were episodes of trying to pull out the tracheostomy tube, however, if the freedom splint was applied properly, he could not pull out the tube. An interview was conducted with LVN 6 on 7/13/15 at 0725 hours. LVN 6 was asked if Resident 1 had episodes of pulling out his tracheostomy tube. LVN 6 stated she witnessed Resident 1 pulling out his tube one time; however, he could not reach it with the freedom splint on. During an interview with CNA 4 on 7/13/15 at 0840 hours, CNA 4 stated, with the freedom splint on, Resident 1 could not reach his tracheostomy tube. CNA 4 stated the resident tried before, but he could not. CNA 4 was asked if the resident had tried recently to pull out his tracheostomy tube. CNA 4 replied no. An interview was conducted with RN 2 on 7/13/15 at 1325 hours. RN 2 stated Resident 1 had hand mittens before and, since there were no episodes of pulling out the tracheostomy tube, they had used a less restrictive restrain, which was the	F 329		

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F 329	Continued From page 30 freedom splint. RN 2 was asked if the freedom splint was effective in preventing the resident from pulling out his tracheostomy tube. RN 2 acknowledged the freedom splint was effective. She was asked why Resident 1 required administration of buspirone every eight hours routinely. She stated the resident still had episodes of trying to pull out the tube. She was informed monitoring of the behaviors for pulling out life sustaining tubes was inconsistent. She reviewed the MAR for June 2015 and acknowledged the documentation was inconsistent but was unable to explain why. She was informed there was no monitoring for orthostatic hypotension as ordered by the physician. She reviewed the clinical record and verified the findings. 2. Clinical record review for Resident 18 was initiated on 7/10/15. Resident 18's clinical record showed the resident was admitted to the facility on 2/24/15. Resident 18's H&P dated 2/25/15, showed diagnoses of schizophrenia and dementia. Review of Resident 18's physician's orders dated 2/25/15, showed to administer Depakote ER 250 mg one tablet by mouth two times a day for manic disorder manifested by persistent agitation/restlessness. Another physician's order dated 6/18/15, showed to administer Depakote ER 250 mg one tablet by mouth once a day for manic disorder manifested by persistent agitation/restlessness. According to Lexi-Comp Online Depakote ER carried a U. S. Boxed Warning for hepatic failure, resulting in fatalities and severe pancreatitis. Lexi-Comp further showed liver function tests	F 329		

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F 329	Continued From page 31 should be performed at regular intervals following initiation of therapy with Depakote ER. Monitor patients closely for appearance of malaise, weakness, facial edema, jaundice, and promptly evaluate symptoms of abdominal pain, nausea, vomiting, and/or anorexia. On 7/13/15 at 1130 hours, an interview and concurrent clinical record review was conducted with LVN 7. When asked to describe Resident 18's behaviors, LVN 7 stated the resident was cooperative, further stating, when asked, the resident did not act out, did not refuse care, and was not a danger to herself or others. LVN 7 stated Resident 18 did talk to herself and made motions as if another person was speaking to the resident, however, did not have hallucinations. When asked about the indication and behavior manifestations for Resident 18's use of Depakote ER, LVN 7 stated it was for a manic state manifested by persistent agitation or restlessness. When asked to define what was meant by persistent agitation and restlessness, LVN 7 paused, then stated moving around. When asked if she would consider moving around as a behavior manifestation, LVN 7 stated no. When asked if there was a way to objectively measure persistent agitation and restlessness, LVN 7 paused, then stated the resident did not manifest any behaviors, and agreed agitation and restlessness were not specific measurable behaviors. LVN 7 was asked what side effects were monitored for Resident 18 related to the use of Depakote ER. LVN 7 showed Resident 18's MAR which showed to monitor the resident for cognitive impairment, Parkinsonism syndrome,	F 329		

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F 329	Continued From page 32 orthostatic hypotension, akathisia, and tardive dyskinesia. When asked if Depakote ER carried a Black Box Warning, LVN 7 did not answer. When asked if she knew what a Black Box Warning was, LVN 7 stated she did not. LVN 7 reviewed a drug reference book kept on the unit, which showed Depakote ER carried a Black Box Warning for risk of liver failure and pancreatitis. When LVN 7 reviewed the bubblepack of Depakote ER, it showed a label for a Black Box Warning. LVN 7 verified she had not noticed the warning label on the Depakote ER bubblepack. LVN 7 verified signs and symptoms of liver failure and pancreatitis were not being monitored. LVN 7 was asked to show Resident 18's liver function had been monitored. LVN 7 reviewed Resident 18's clinical record and failed to locate liver function test results. LVN 7 stated she would call Resident 18's physician to obtain orders for liver function tests. 3. Review of the facility's P&P titled Pain Assessment and Management (undated) showed the facility should assess each resident who is experiencing pain or may have a condition or receives care/services in which pain may reasonably be anticipated. Pain will be monitored based on the specific needs of the resident and the pain medications. Review of the facility's P&P titled Pain Management-Indications of Pain (undated) showed pain medication will be administered to the residents 20 to 30 minutes prior to therapy treatments. During the medication pass observation with LVN 4 on 7/9/15 at 1028 hours. LVN 4 administered	F 329		

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F 329	Continued From page 33 Tylenol 325 mg two tablets to Resident 14. However, LVN 4 did not assess the resident for pain prior to administration of the pain medication. LVN 4 was asked if she needed to assess the resident for pain prior to administration of pain medication. She replied yes. Clinical record review for Resident 14 was initiated on 7/9/15. Resident 14 was admitted to the facility on 4/30/15. The MDS dated 5/7/15, showed the resident was cognitively intact. Review of the physician's orders dated 6/24/15, showed Resident 14 received occupational therapy and physical therapy daily five times a week. Review of the clinical record showed the resident had been administered Tylenol 325 mg two tablets daily continuously seven days a week from 5/2015 to 7/1/15, not based on the resident's need. Review of the physician's order dated 4/30/15, showed the following orders: - Tylenol 325 mg, two tablets by mouth daily for pain management. - Tylenol 325 mg; two tablets by mouth every 4 hours as needed for mild pain. - Norco (pain medication) 10/325 mg, one tablet by mouth every 4 hours as needed for moderate to severe pain. Review of the Pain Assessment Flowsheet for the months of May to July 9, 2015, showed Resident 13 did not complain of any pain. However, Resident 13 was continuously receiving Tylenol	F 329		

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F 329	Continued From page 34 325 mg two tablets daily seven days a week from May 1, 2015 through July 9, 2015, without assessing the resident's pain. During the observation on 7/13/15 at 0905 hours, Resident 14 was observed propelling his wheelchair in the hallway. He was asked if he went to rehab therapy and if he got his pain medication prior to his therapy. Resident 14 stated he did not need his pain pills and did not have any pain. A follow-up interview and concurrent clinical record review was conducted with LVN 4 on 7/13/15 at 1332 hours. LVN 4 was asked why Resident 14 was receiving Tylenol. LVN 4 was unable to identify the indication of Resident 14's use of Tylenol. She stated all residents admitted in the facility were placed on a routine Tylenol order for pain management when residents were in rehab. An interview and concurrent facility P&P review was conducted with the DON on 7/13/15 at 1622 hours. The P&P was reviewed with the DON. The DON stated all residents admitted to the facility were placed on Tylenol for pain management before the residents started on rehab therapy. She added it was a standing order in the facility. The DON showed the above P&P to to justify the reason for administering routine Tylenol to all residents receiving rehab therapy.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	F 371 Upon notification, cook immediately covered scratch on right forearm with waterproof dressing. Cook immediate in-serviced on infection control practices and skin integrity procedure by DSD.	07/09/2015

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F 371	Continued From page 35 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 facility document review, the facility failed to ensure food and food preparation equipment were stored under sanitary conditions. * The cook had an uncovered open scratch on his forearm. * The ice machine had a visible black substance on the inside surface. * A carton of eggs was not dated or labeled. * A bag of opened biscuit mix was not dated or labeled. These failures created a risk for cross-contamination, food contamination, and the potential for foodborne illnesses to the residents who received food prepared in the facility's kitchen. Findings: Review of Form CMS-672 Resident Census and Conditions of Residents completed by the DON on 7/8/15, showed the facility had a census of 104 residents. Of these, 42 residents were	F 371	Maintenance Supervisor immediately shut down the ice machine, emptied and thoroughly cleaned with descaler. Upon notification, carton of eggs and bag of opened biscuit mix were immediately disposed and replaced by the Dietary Service Supervisor. The Dietary Service Supervisor checked all food supplies in the kitchen to ensure all open items are labeled and dated. No other items were found with the same deficient practice. Maintenance Supervisor completed rounds in kitchen to ensure all equipment was clean and in good, working condition. No further potential risks identified. An in-service was given to all staff by the Infection Control Coordinator/DSD on 07/14/2015 and was completed on 07/31/2015 regarding employees that skin integrity issues should be completely covered by suitable waterproof dressing before starting work. An in-service was given to all dietary staff by the Dietary Service Supervisor on 07/08/2015 and was completed on 07/17/2015 regarding proper food labels and dating procedure. Dietary Service Supervisor will include during daily rounds to ensure all food items are properly dated or labeled and monitoring dietary employees with skin integrity issues to not potentially contaminate food. Maintenance Supervisor will deep clean the ice machine monthly under the supervision of the Dietary Service Supervisor. The Dietary	07/10/2015 07/08/2015 07/08/2015 07/10/2015 07/31/2015 07/17/2015

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F 371	Continued From page 36 receiving nutrition via GT feeding and 62 residents received meals prepared in the kitchen. a. Review of facility's P&P titled Infection Control for the Food Service Department showed employees with skin integrity issues should have the area completely covered by suitable waterproof dressings and/or gloves. During the observation of meal preparation on 7/9/15 at 0930 hours, the cook was observed with an open scratch on his forearm. During an interview with the DSS on 7/9/15 at 1550, she stated she told the cook to go to the treatment cart and get the open scratch covered, but he did not. The DSS verified the policy was to have the open wound covered. b. On 7/10/15 at 0840 hours, an inspection of the facility's ice machine was initiated with the Maintenance Supervisor and DSS. An observation of the ice machine in the kitchen and concurrent interview was conducted. The Maintenance Supervisor confirmed there was only one ice machine in the facility. The Maintenance Supervisor was asked how often the ice machine was cleaned and who was responsible for cleaning the ice machine. He stated he cleaned the inside of the ice machine monthly with a descaler and the dietary staff cleaned the outside. Review of the ice machine cleaning log showed it was last cleaned on 6/2/15. The Maintenance Supervisor removed the front panel of the ice machine which contained the	F 371	Supervisor will visually inspect the ice machine to ensure cleanliness. All findings are reported and tracked at our QA Committee Quarterly for evaluation and further action.	

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F 371	Continued From page 37 electrical components of the machine. A visible black substance was observed surrounding a white tubing. On the inside panel, a white, scaly substance was observed along the width of the panel. The Maintenance Supervisor and DSS verified the findings. c. A tour of the kitchen was initiated on 7/8/15 at 1350 hours. A carton of eggs was found in the refrigerator with no date. The DSS verified the finding. d. During an inspection of the dry storage room, two zip lock bags of open biscuit mix were observed with no date. The DSS verified the finding.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility document review, the facility failed to act upon the Pharmacy Consultant's drug regimen recommendations for one of 21 sampled residents (Residents 18). Additionally, the facility	F 428	F 428 The Interdisciplinary Team reviewed medication and behavior monitoring for Resident 18 from admission. Resident 18 did not display any behavior, the team recommended that her Depakote to be reduced from twice a day to once a day. Resident 18's Depakote discontinued at IDT meeting with the Psychiatrist on 07/27/2015. Per physician's order, Resident 18's liver function test was completed on 07/14/2015. Result returned normal level that was relayed to physician with no new order.	07/27/2015 07/14/2015

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F 428	Continued From page 38 failed to ensure the Pharmacy Consultant reported irregularities in the drug regimen for two of 21 sampled residents (Residents 18 and 14). This had the potential for residents to receive medications inappropriately, for a longer duration than necessary, or without adequate monitoring. Findings: 1. Clinical record review for Resident 18 was initiated on 6/10/15. Resident 18 was admitted to the facility 2/24/15. Review of Resident 18's admission orders dated 2/24/15, showed to administer Depakote ER 250 mg by mouth twice a day for manic state manifested by persistent agitation/ restlessness. Review of Resident 18's current physician's orders showed an order dated 6/18/15, to administer Depakote ER 250 mg one tablet by mouth one a day for manic state manifested by persistent agitation/ restlessness. Review of Resident 18's Consultant Pharmacists Medication Regimen Review since the resident's admission on 2/24/15, showed four recommendations dated 3/30, 4/17, 5/22, and 6/23/15. All four showed the same recommendations related to Resident 18's Depakote ER: "Persistent agitation/restlessness was not an acceptable behavior manifestation. Behavior manifestations must be objective and quantitatively measurable. for example, behaviors as physical abuse (hitting, kicking, biting, pinching, shoving, scratching, grabbing; verbal abuse - threatening, screaming, cursing at others) causing impairment in functional capacity; injuring self or others (specify how); any specific behavior causing fearful distress, etc. Please	F 428	Resident 14's Tylenol order will be continued by the licensed nurse to be administered as ordered by the physician. Resident was admitted with cellulitis and Stage III on left foot. Resident 14 is receiving occupational therapy and physical therapy five times a week. The DON gave an in-service to all licensed nurses on duty regarding proper pain assessment and documentation before administering pain medication. The DON and ADON reviewed all Pharmacy Recommendations from the past six months to ensure all drug regimen recommendations are followed or properly documented as to why recommendation was not followed. No other residents were affected with the same deficient practice. An in-service was given to all licensed nurses by the DON/ADON on 07/14/2015 and was completed by 07/31/2015 regarding proper assessment and documentation before administering medication. The DON/ADON will continue to review all Pharmacy Drug Regimen recommendations to ensure each item were followed up on. Medical Records Designee will conduct a monthly audit on Pain Assessment Flowsheet for completion. The DON will review monthly audits and pharmacy consultant's drug regimen review recommendation if followed and carried	07/14/2015 07/14/2015 07/31/2015

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F 428	Continued From page 39 review." The facility's documented responses to the Pharmacy Consultant's recommendations on the Consultant Pharmacists Medication Regimen Review forms were as follows: * For 3/30/15, "will discuss with Dr. (name)." * For 4/17/15, Was blank; there was no documented response. * For 5/22/15, "patient not kicking, cursing hitting, biting, shoving." * For 6/23/15, "D/C 6/18/15." However, the Depakote ER was not discontinued on 6/18/15; the medication dose was reduced from 250 mg twice a day to 250 mg once a day. Review of the Pharmacy Consultant's drug regimen recommendations failed to show a recommendation to monitor Resident 18's liver function. On 7/13/15 at 1430 hours, during an interview with the DON, she verified the above findings. A follow-up interview was conducted with the DON on 7/16/15 at 1030 hours. The DON was asked to describe the facility's process when the Pharmacy Consultant's recommendations were received. The DON stated she reviewed each recommendation, then gave it to the RN Supervisors for follow up. The RN Supervisor was to call the physician and document the physician's response. When asked where the RN Supervisors documented the physician's response, the DON stated on the physician's order if there was a new order, and in the nursing progress notes. The DON further stated she obtained an order on 7/13/15, for a liver function panel for Resident 18.	F 428	out. Findings will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	

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F 428	Continued From page 40 Review of Resident 18's License Nurse Record showed documentation the resident's physician was notified of the Pharmacy Consultant's recommendations. The documentation showed Resident 18's physician gave no new orders; however, the nurses documented to follow up with the psychologist. The clinical record showed no documentation the nursing staff notified Resident 18's psychologist of the Pharmacy Consultant's recommendations regarding the resident's Depakote ER. 2. Clinical record review for Resident 14 was initiated on 7/9/15. Resident 14 was admitted to the facility on 4/30/15. The MDS dated 5/7/15, showed the resident was cognitively intact. Review of the physician's order dated 6/24/15, showed Resident 14 received occupational therapy and physical therapy daily, five times a week. The clinical record showed the resident's had been administered Tylenol 325 mg, two tablets daily continuously seven days a week from 5/2015 to 7/1/15, not based on the resident's need. Review of the physician's order dated 4/30/15, showed the following orders: - Tylenol 325 mg two tablets by mouth daily for pain management. - Tylenol 325 mg two tablets by mouth every 4 hours as needed for mild pain. - Norco (pain medication) 10/325 mg one tablet by mouth every 4 hours as needed for moderate-severe pain.	F 428		

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F 428	Continued From page 41 Review of the Pain Assessment Flowsheet for the months of May to July 9, 2015, showed Resident 13 did not complain of any pain. However, Resident 13 was continuously receiving Tylenol 325 mg two tablets daily seven days a week from May 1, 2015 through July 9, 2015, without accurately assessing resident's pain. A telephone interview was conducted with the Pharmacy Consultant on 7/14/15 at 1001 hours. The above concerns were discussed with the Pharmacy Consultant. He was asked if he reviewed Resident 13's medication. He stated he reviewed the resident's medications twice during the resident's stay in the facility. The Pharmacy Consultant was asked why, during his drug regimen review, he had not made any recommendations or questioned the above concerns. The Pharmacy Consultant stated he did not see any irregularities during his review and did not leave any comments and recommendations. Cross reference to F329, example #3.	F 428		
F 441 SS=D	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;	F 441	F 441 Upon notification, the Staff Member was immediately sent to the clinic to receive a medical follow up following needle stick injury. Staff Member was seen and evaluated on 07/15/2015, next follow up appointment is 09/02/2015. The Infection Control Designee/DSD reviewed all work related injury from January 2015 to present to ensure all employees with work related injuries received timely medical follow ups following injury. No other employees were affected with the same deficient practice.	07/15/2015 07/14/2015

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F 441	Continued From page 42 (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 infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an employee received timely medical follow up following a needle stick injury. This had the potential for delays in recognition and medical treatment of potentially communicable infectious diseases. Findings: On 7/10/15 at 1400 hours, an interview and concurrent facility document review was	F 441	An in-service was given to all staff by the Infection Control Designee/DSD on 07/14/2015 and was completed on 07/31/2015regarding work injury clinic appointments. All medical follow up appointments must be followed. The Infection Control Designee/DSD will monitor all work related injuries through his initiated tracking log to ensure all medical follow up following an injury are completed. All findings will be reported and tracked at our QA Committee Quarterly for evaluation and further action.	07/31/2015

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F 441	Continued From page 43 conducted with the DSD. The DSD was asked if the facility had any sharps injuries in the past year. The DSD stated they had one staff member who sustained a needle stick to the finger after administering an injection to a resident. Review of the Accident Investigation Form dated 3/1/15, showed although the area for "unsafe material handling" was marked "yes," the area to document "what was done unsafely," "why it was done that way," and "how will it be controlled" were marked "0;" the area to document "who will assume responsibility" was blank. The DSD verified the findings on the form and stated the staff member had not immediately engaged the safety device on the syringe and had been provided a sharps safety inservice following the injury. The DSD stated the staff member was referred to the clinic for evaluation and follow up Review of the documentation of follow-up care showed the staff member received initial treatment 3/5/15, and returned for follow up as ordered two weeks later on 3/19/15. On 3/19/15, the staff member was instructed to follow up on 4/16/15, for laboratory tests; however, the staff member returned to the clinic on 5/26/15, more than a month late. On 5/26/15, the staff member was instructed to follow up in two weeks. As of review date of 7/10/15, the staff member had not returned to the clinic for follow up. The DSD verified the above findings. When asked for the facility's P&P for sharps injuries, the DSD stated there was no facility P&P. The facility followed the guidelines from their worker's compensation department. The DSD was asked what the facility's process was for tracking and ensuring the follow up for	F 441		

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F 441	Continued From page 44 sharps injuries. The DSD stated he had no system for tracking and relied on the clinic to send him a notice for the staff member to return for follow up. The DSD stated he would follow up with the clinic and schedule a follow-up visit for the staff member.	F 441		
F 455 SS=E	483.70(b) EMERGENCY ELECTRICAL POWER SYSTEM An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to supply emergency electrical power with an emergency generator from 6/8/15 to 6/10/15. This created the risk of resident life support. Findings: On 7/9/15 at 0840 hours, a concurrent interview and environmental tour was conducted with the Maintenance Supervisor. Review of the Emergency Generator Checklist showed a notation on 6/8/15, "emergency generator's	F 455	F 455 Upon notification, the Administrator with the collaboration of QA Committee immediately developed a guideline and a written plan in the event of emergency generator failure or malfunction. The Administrator reviewed Generator Log to ascertain if there were further unusual events or incidents related to failure to supply emergency electrical power by the emergency generator. No events or incidents were identified related to the failure of emergency generator. An in-service was given to all staff by the Administrator on 07/15/2015 and was completed on 07/31/2015 regarding plan of action in the event of emergency generator failure of malfunction. Plan of action includes guidelines in reporting, duties and responsibilities, availability of resources, and emergency contact lists. The Maintenance Supervisor and the Administrator will continue to monitor and test the emergency generator weekly. All findings will be reported and tracked at out QA Committee Quarterly for evaluation and further action.	07/15/2015 07/09/2015 07/31/2015

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F 455	Continued From page 45 battery was out. (Vendor name) inspector came and replaced the battery." The Maintenance Supervisor stated the generator was not working when he performed the weekly load test on 6/8/15. He further stated he reported this to the Administrator and called the vendor to come and replace the battery. On 7/9/15 at 0900 hours, an interview was conducted with the Administrator who was unable to state the time frame the generator was not operational. When asked to provide documentation, he was able to obtain a work order from the vendor dated 6/10/15, for the work done to replace the battery to the generator. On 7/9/15 at 0940 hours, an interview was conducted with the DON who was asked what plan was in place for the facility's function and especially the residents who were ventilator dependent and in use of electrical devices if there was a power outage and the generator was not operational. The DON was unable to state an emergency plan. The DON further stated she was unaware of how long the generator was inoperable but thought it was fixed right away. Review of the residents' census showed on 6/8, 6/9, and 6/10/15, there were 20, 21, and 20 residents dependent on ventilators respectively. On 7/9/15 at 0955 hours, an interview was conducted with RT 2 who was not aware the generator was inoperable at any time. RT 2 stated the plan in a power outage would be to rely on the battery power of the ventilators if fully charged (approximately 10 hours), then manually resuscitate the residents with a bag valve mask and call 911. When asked how many staff would	F 455		

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F 455	Continued From page 46 be available to resuscitate, he stated all nurses, RTs, and CNAs. RT 2 stated there would not be enough staff in the facility to cover 20 to 21 ventilator dependent residents. On 7/9/15 at 1140 hours, the Administrator provided a copy of the vendor's invoice showing the generator battery was replaced on 6/10/15.	F 455		
F 465 SS=D	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 and interview, the facility failed to maintain a safe, functional, and sanitary environment in two resident rooms in the facility. This had the potential to create injuries to the residents, staff, and visitors. Findings: On 7/9/15 at 0810 hours, an environmental tour was conducted with the Maintenance Supervisor. An observation of the floor in Room A showed four raised areas on the linoleum at the foot of the resident's bed. Room B showed a 4 inch raised crack in the linoleum floor, covering around the toilet in the bathroom.	F 465	F 465 Upon notification, Maintenance Supervisor immediately removed affected linoleum tiles in room A and B, and replaced with new flooring materials. Maintenance Supervisor conducted rounds of all resident rooms and evaluated all flooring for potential hazards. No other resident rooms were affected with the same deficient practice. An in-service was given to all staff by the DON/ADON on 07/14/2015 and was completed 07/31/2015 regarding reporting potential accident hazards to RN Supervisor for notification of Maintenance Supervisor. RN Supervisor will report any potential hazards to Maintenance staff via Maintenance Log for immediate rectification. Maintenance Supervisor to complete room rounds daily to identify potential hazards and check Maintenance Log each shift. Administrator to review Maintenance Log monthly with Maintenance Supervisor to ensure completion and identify patterns in potential hazards. All findings will be corrected immediately and it will be reported at our QA Committee Quarterly for evaluation and further action.	07/09/2015 07/09/2015 07/31/2015

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F 465	Continued From page 47 The Maintenance Supervisor verified these were potential hazards for the residents, staff, and visitors.	F 465		
F 493 SS=E	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and facility P&P review, the facility failed to ensure the facility's P&Ps for antipsychotic medication use in residents with a diagnosis of dementia and the use of psychotropic medications were complete and provided adequate guidelines for implementation of the P&Ps. * The P&P to address antipsychotic medication use for residents with dementia failed to include how the facility would initially assess the resident for appropriate use, when and how to reassess for continued need, and guidelines for attempting gradual dose reduction and discontinuation of the medications. * The P&P for the use of psychotherapeutic medications failed to include the indications and	F 493	F 493 The Administrator with the collaboration of QA Committee revised facility's P&P for anti-psychotic medication use for residents with a diagnosis of dementia that includes procedure on how and when to reassess for continued need and attempt for gradual dose reduction and discontinuation of medication. Policy was reviewed and approved by the committee during last QA Committee Quarterly meeting. The Administrator with the collaboration of QA Committee reviewed all facility's P&P related to behavior management to ensure it includes both a policy and a procedure. No other P&P were identified with the same deficient practice. An in-service was given to all licensed nurses by the DON on 07/24/2015 and was completed on 07/31/2015 regarding revised P&P for anti-psychotic medication use in residents with a diagnosis of dementia. The P&P includes how the facility would initially assess the resident for appropriate use, how to reassess for continued need, and guidelines for attempting gradual dose reduction and discontinuation of medication. The QA Committee will ensure all developed facility P&P are complete and provides adequate guidelines for implementation of the P&P. This will be discuss at our QA Committee Quarterly for evaluation and further action.	07/24/2015 07/24/2015 07/31/2015

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F 493	Continued From page 48 frequency of gradual dose reduction of the medications. These created the risk for residents to receive these medications inappropriately, unnecessarily or for a longer duration than was needed. Findings: 1. During the entrance conference with the Administrator on 7/8/15 at 1400 hours, he was asked for the facility's P&P for the use of antipsychotic medications in residents with a diagnosis of dementia. Review of the P&P provided, titled Antipsychotic Drug Use with Dementia (undated) showed the following, "Policy: This facility will assess residents who have dementia and have orders for antipsychotic medications in an attempt to reduce, taper and/or discontinue the antipsychotic medication." On 7/9/15 at 0800 hours, an interview was conducted with the Administrator. When asked if this was the above P&P in its entirety, the Administrator stated he would check. When he returned, the Administrator stated, "Yes." The Administrator acknowledged the P&P was undated, included only a policy and no procedure, and did not show the facility's name. In a follow-up interview with the Administrator on 7/15/15 at 1328 hours, he was asked the origin and date of the P&P. The Administrator stated the facility developed the P&P last year. When asked about the process for reviewing and accepting facility P&Ps, the Administrator stated the facility conducted a P&P review annually and	F 493		

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	555035	A. BUILDING _____ B. WING _____	07/16/2015

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F 493	Continued From page 49 stated the antipsychotic drug use with dementia P&P had been reviewed and accepted in November 2014. When asked who participated in the review of facility P&Ps the Administrator stated himself, DON, Medical Director, and all department heads. Review of the facility's document titled Policy and Procedure Review Annual Update dated 11/21/14, showed Pharmacy and Nursing: SNF and Sub-acute manuals were reviewed and approved. However, it did not show any specific P&Ps. The Administrator was asked how the nursing staff would know how to implement the P&P for residents with a diagnosis of dementia who were prescribed antipsychotic medications by reading the facility's current P&P. The Administrator acknowledged the P&P did not provide any guidance for implementing the policy and stated, "We will have to look at that." 2. Review of the facility's P&P titled Psychotherapeutic Medications (undated) showed psychotropic medications are to be used only for specific behaviors by a resident, quantitatively and qualitatively documented by the facility. Drug holidays and gradual dose reductions are to be encouraged as the resident's condition allows. During an interview with the Administrator and DON on 7/13/15 at 1330 hours, they were asked when the facility should initiate a gradual dose reduction. The DON stated they had to attempt gradual dose reductions two times a year. However, they were informed the facility's P&P did not include the indication and frequency of gradual dose reductions of the psychotropic	F 493		

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F 493	Continued From page 50 medications.	F 493		
F 514 SS=D	483.75(l)(1)-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient 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 clinical record review and interview, the facility failed to ensure the clinical record was complete for one of 21 sampled residents (Resident 20). * The Physician's orders were not dated in a timely manner in Resident 20's clinical record. This created the risk of not providing proper care to Resident 20 due to incomplete clinical documentation. Findings: According to facility's P&P titled Facility Administration Responsibilities for the Attending Physician, the physician must sign telephone orders and return them to the resident's record	F 514	F 514 Upon notification, Resident 20's closed clinical records were reviewed, signed, and dated by the physician assisted by the Medical Records Designee. Medical Records Designee conducted an audit on all physician's orders (open records) and all residents discharged from the 01/01/2015 (closed charts) to ensure records were complete. No other residents were affected with the same deficient practice. A memorandum was sent to all physicians by the Administrator reminding physicians of the responsibilities for attending physician at facility. All physician's telephone orders must be signed, dated, and returned to the resident's record within five days. The Medical Records Designee will conduct a monthly audit on resident's clinical records for completeness of all forms, signed and dated. All findings will be reviewed by the DON/ADON monthly and corrected immediately and will be discussed at our QA Committee Quarterly for evaluation and further action.	07/27/2015 07/27/2015 07/27/2015

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F 514	Continued From page 51 within five days. In addition, the physician must complete the resident's clinical record within 30 days of discharge. On 7/13/15, clinical record review was initiated for Resident 20. Resident 20 was admitted to the facility on 4/3/15, and discharged on 5/1/15. Review of the physician's orders dated 4/3/15 to 5/1/15, the section for the physician to date each written order was left blank. On 7/13/14 at 0820 hours, a concurrent clinical record review and interview was conducted with the DON. The DON verified the physician's orders were not dated.	F 514		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility P&P review, the facility failed to ensure three of eight staff members (RN 5, CNA 3, and CNA 1) were knowledgeable of the facility's emergency procedures, creating the risk of placing staff, residents, and visitors in danger in the event of an emergency situation. Findings:	F 518	F 518 Upon notification, RN 5, CNA 3, and CNA 1 were in-serviced immediately by the Maintenance Supervisor and DSD and provided return demonstration of facility emergency procedures and shut off practices. Gas and water shut off valves were painted with contrasting colors for immediate identification and signs posted to each valve. All staff in-service conducted by DSD and Maintenance Supervisor on 07/08/2015 and completed 07/30/2015 regarding facility emergency procedures. Educational material's developed, with pictures, by the Administrator and DSD in the Fire and Disaster Manual- Education Section. Materials to be used for future	07/13/2015 07/30/2015 07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTIDN	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIDN	(X3) DATE SURVEY CDMPLETED
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F 518	Continued From page 52 Review of the facility's P&P titled Emergency Shutoffs (undated) showed the emergency gas shut off valve is located outside the building by the laundry room by the gas meter. On 7/8/15 at 1651 hours, an interview was conducted with Maintenance Staff 1. He stated to turn off the gas shut off valve, the staff would need the wrench placed next to the valve and turn the valve to the right to turn off the gas. The correct shut off valve was located at the bottom, next to the wrench. 1. On 7/8/15 at 1610 hours, an interview was conducted with RN 5 regarding the facility's emergency procedures. RN 5 was asked to locate the facility's main gas shut off valve and demonstrate how to turn off the main gas during an emergency. After walking to the location of the gas meter, RN 5 was unable to identify the correct main gas valve to demonstrate how to turn it off. 2. On 7/8/15 at 1646 hours, an interview was conducted with CNA 3 regarding the facility's emergency procedures. CNA 3 was asked to locate the facility's main gas shut off valve and demonstrate how to turn off the main gas during an emergency. After walking to the location of the gas meter, CNA 3 stated he was unsure which valve to turn off and was unable to identify the correct main gas valve to demonstrate how to turn it off. 3. Review of the facility's P&P titled Emergency Shutoffs (undated) showed the water shut off valve is located outside of the facility at the back of resident room 212, by the street to the west.	F 518	new hire orientations and training purposes. Poster of emergency shut off locations and emergency codes posted with safety board. All Staff to be in-serviced by the DSD on emergency procedures upon hire and semi-annually. QA Committee to review emergency procedures as needed for updates to ensure consistency and current practices. This will be monitored monthly by the Administrator and the DSD, by interviewing and ask emergency procedure questions to 10 random employees. This will be reported at our QA Committee Quarterly for evaluation and further action.	

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F 518	Continued From page 53 During an interview with CNA 1 on 7/9/15 at 0635 hours, CNA 1 was asked to locate the facility's water shut off valve. CNA 1 was able to locate the facility's water shut off valve; however, when CNA 1 was asked how to turn off the water, she stated she would turn the middle knob upward. It was observed a sign was posted, "Water Shut Off" with an arrow pointing to a knob at the lower left side of the water shut off valve. An interview was conducted with the Maintenance Supervisor on 7/13/15 at 1410 hours. The Maintenance Supervisor was asked to demonstrate how to turn off the facility's water. He went to the facility's water shut off valve and demonstrated to turn the knob at the lower left side of the water shut off valve. He was asked if the staff turned the middle knob, it would shut off the water to the facility. He replied no, it should be the lower left side knob.	F 518		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F 520 A follow up letter with conclusion of the investigation on 12/20/2014 was sent to the Department of Health Services immediately by the Administrator. An in-service was given to all staff by the Administrator and DON on 07/14/2015 and was completed by 07/31/2015 regarding quality assessment and assurance committee (QA), members of QA committee, and purpose of QA committee.	07/23/2015 07/31/2015

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F 520	Continued From page 54 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, the facility failed to implement an effective QA program with a committee that identified quality deficiencies, developed and implemented plans of actions to correct the deficiencies, monitored the effectiveness, and revised the action plans as needed. Additionally, five of eight staff members interviewed (RN 3, RN 4, RN 5, OT 1, and CNA 6) were unable to identify current QA projects. Failure to have an effective QA program had the potential to negatively affect the quality of care for all residents in the facility. Findings: On 6/13/15 at 1330 hours, an interview and concurrent facility document review was conducted with the Administrator and DON. The Administrator was asked how the QA committee identified issues for committee action. The Administrator stated through daily morning meetings, resident council concerns, pharmacy recommendations, department head reports, consultant input, and review of monitoring tools. When asked how the QA committee developed	F 520	The QA Committee reviewed previous recertification survey identified issues and plan of correction on 07/24/2015. Four out of sixteen deficiencies were identified as repeated on this year's recertification survey. Plan of corrections were reviewed from previous year and identified reasons for failure. The QA Committee developed a new plan of correction to address all deficiencies identified on this year's recertification. An in-service was given to all staff by the Administrator and DON on 07/14/2015 and was completed by 07/31/2015 to communicate identified quality issues and deficiencies. Staff educated that a plan of action was developed and must be implemented immediately. A QA section will be included on the employee communication board located in the employee lounge for announcements and updates monthly. All issues identified by QA Committee will be assigned to a corresponding sub-committee chairperson to be responsible for monitoring progress and for needed revisions to plan of action. All findings and progress will be reported to the QA Committee Chairman and will be discussed at our QA Committee during monthly meeting for evaluation and further action.	07/31/2015 07/31/2015

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F 520	Continued From page 55 action plans for identified quality issues, the Administrator stated the committee team members met and gave suggestions, used resources such as consultants, physicians, current P&Ps, licensing agency, and ombudsman and referred to professional resources such as standards of practice and new research. The Administrator was asked what the facility's current QA projects were. The Administrator did not initially answer. When asked if there was anything the QA committee was working on, the Administrator stated they were working on ensuring abuse investigations were complete. When the Administrator was asked for the action plans, he showed the POC for an abbreviated survey dated 4/14/15, for a deficient practice cited at F226. The POC showed the Administrator and DON reviewed all abuse allegation investigations from January 2014 through the present (4/15/15) to ensure each was complete. However, during the abuse protocol interview with the Administrator on 7/10/15 at 0900 hours, review of an abuse investigation dated 12/30/14, showed the investigation did not follow the facility's abuse investigation P&P: the facility failed to notify the CDPH of the conclusion of their investigation in accordance with their abuse investigation P&P. When the Administrator was asked if the facility's QA committee had identified any other quality issues/deficiencies for which they had developed an action plan and were currently implementing, he stated they were not currently working on any other projects. The Administrator was informed repeated deficiencies from the facility's previous recertification survey completed on 6/19/14, were	F 520		

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F 520	Continued From page 56 identified during the current recertification survey related to accident hazards in resident rooms, development and revision of resident care plans, unnecessary medications, and unsanitary conditions in the kitchen. The POC from the last recertification survey was reviewed with the Administrator and DON. The findings were as follows: * The previous recertification survey identified a cabinet in a resident room as a potential environmental hazard, cited at F253. The current recertification survey identified two potential environmental accident hazards: an unsecured refrigerator stacked on top of a cabinet and an unsecured electric fan on top of a shelf, cited at F323. The POC for the previous recertification survey showed the staff were provided an inservice on reporting maintenance needs in the maintenance log and the Maintenance Supervisor would make daily room rounds. When the Administrator was asked if the daily room rounds were to made in every room, he stated yes. The Administrator was asked if the staff were provided an inservice on reporting maintenance needs, and the Maintenance Supervisor was making daily rounds in every room and did not identify the accident hazards. The Administrator acknowledged the accident hazards should have been identified. The Administrator was asked to show evidence the staff inservice had been completed and the Maintenance Supervisor made daily rounds to every resident room and reported safety findings at the QA committee meetings. The Administrator showed documentation of daily room rounds had been made; however, the daily	F 520		

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F 520	Continued From page 57 room rounds were not made to every room everyday. The Administrator reviewed the QA meeting minutes for July through December 2014 and was unable to locate evidence the Maintenance Supervisor reported safety findings. * The previous recertification survey showed the facility failed to develop, review, and revise resident comprehensive care plans. The current recertification survey identified a repeated deficient practice; both were cited at F279. The POC for the previous recertification survey showed the licensed nurses were provided an inservice on care planning, the DON/ADON would perform weekly random audits of care plans until 100% compliance was achieved and any issues would be discussed at the QA meeting for follow up as needed. The Administrator was asked to show evidence the POC had been implemented and reported during the QA committee meetings. The Administrator was unable to show evidence of weekly audits of care plans. The Administrator reviewed the QA committee meetings from July through December 2014 and was unable to locate any reports on care plan issues. * The previous recertification survey showed the facility failed to ensure residents are free from unnecessary drugs as evidenced by the behavior manifestations being monitored were inappropriate to justify use of the drug. The current recertification survey identified the facility failed to identify appropriate behavior manifestations to justify the use of antipsychotic medications and failed to accurately monitor behaviors, side effects, and Black Box Warnings for the medications; both were cited at F329.	F 520		

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F 520	Continued From page 58 The POC for the previous recertification survey showed the facility would provide inservices to the licensed nurses to identify appropriate behavior manifestation and provide monthly behavior management reviews and update behavior management IDT monthly. Additionally, the Pharmacy Consultant would monitor the process monthly, the DON would review all new orders to ensure specific behavior manifestations, and findings would be discussed monthly for follow up in the QA meetings. When asked to show evidence the POC had been implemented and monitored, the DON showed logs which included review of behavior manifestations; however, the current deficiencies were not identified through the process. The Pharmacy Consultant performed monthly drug regimen reviews which did identify irregularities related to inappropriate behavior manifestations; however, the facility failed to act upon the recommendations, cited at F428. The Administrator reviewed the QA minutes from July through December 2014 and was unable to locate documentation any findings had been discussed or reported. * The previous recertification survey showed the facility failed to safely store food and follow sanitary practices in the kitchen. The current recertification survey identified unlabeled and undated food items and unsanitary conditions in the kitchen which included the ice machine; both were cited at F371. The POC for the previous recertification survey showed the facility would provide inservices on following facility policies for cleaning and	F 520		

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F 520	Continued From page 59 maintaining kitchen equipment, food expiration dates, labeling of food items, and importance of performing daily rounds to observe cleanliness of the equipment as well as food expiration dates. Additionally, the DSS would perform weekly rounds to check equipment and expired products, the RD would submit a Dietary Quality Control Survey to the Administrator and DSS, and findings and issues would be discussed at the monthly QA meetings. When asked to show the POC had been implemented, the Administrator was unable to show evidence of the weekly rounds by the DSS. The Administrator reviewed the QA minutes for July through December 2014 and was unable to locate evidence findings, issues, or the RD surveys were discussed or reported. When the Administrator was asked how the facility identified any areas of concern for which to develop action plans/QA projects or identify continued deficient practices in the areas identified during the previous recertification survey, he had no answer. When asked what the facility's process was for ensuring their POCs were implemented as written and monitored by the QA committee, the Administrator was unable to answer and stated they would have to work on it. 2. During an interview with RN 3 on 7/9/15 at 1000 hours, RN 3 was asked if she was aware of the facility's QA committee and the projects that were currently being worked on. RN 3 replied no, she was not aware of the QA committee or what projects the facility was working on for performance improvement.	F 520		

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F 520	Continued From page 60 3. During an interview with OT 1 on 7/13/15 at 1115 hours, OT 1 was asked if she was aware of the facility's QA committee and the projects that were currently being worked on. OT 1 replied yes, there was a committee and the projects included restraint reduction and falling star program. Neither of these were identified by the Administrator as current projects in the QA committee during the QA interview on 7/13/15 at 1430 hours. 4. During an interview with RN 4 on 7/9/15 at 0655 hours, RN 4 was asked if she was aware of the facility's QA committee. RN 4 replied no. RN 4 was asked if she knew who the members of QA committee were. RN 4 replied she did not know. RN 4 was asked what the facility's QA projects were. RN 4 replied she did not know. 5. During an interview with CNA 6 on 7/9/15 at 1430 hours, CNA 6 was asked if she was aware of the facility's QA committee. CNA 6 stated she did not know what the QA committee was; however, she stated she had had inservices on falls and hand hygiene. 6. On 7/8/15 at 1610 hours, an interview was conducted with RN 5 regarding the facility's QA program. When asked to identify current QA projects ongoing for the benefits of all the residents as well as the staff, RN 5 stated he did know from the last month's QA project, the facility was working on the proper eye care and infection control.	F 520		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE ND HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 555035	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/16/2015

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PARK ANAHEIM HEALTHCARE CENTER	3435 W BALL ROAD ANAHEIM, CA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 252	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: The facility was in substantial compliance with the requirements of 42 CFR, Part D, Subpart B. 42 CFR, 483.15(h) During an initial tour on 7/8/15 at 1615 hours, a strong smell of urine was observed in Room C. During an interview with CNA 7 on 7/10/15 at 0940 hours, he verified the bathroom always had a strong smell of urine from spillage of urine from emptying a suprapubic catheter. During an interview with RN 7 on 7/10/15 at 1530 hours, in Room C, she verified the urine odor in the room and especially in the bathroom. She stated there must be urine on the floor because the toilet was clean. During an interview with the Administrator on 7/10/15 at 1550 hours, in Room C, he verified the strong urine in the bathroom and stated he would change out the bed in case the urine was soaked in the mattress. The Administrator verified the other resident in the room was nonverbal and unable to express his feeling about the odor or any adverse reactions to the odor.
F 253	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility was in substantial compliance with the requirements of 42 CFR, Part 483, Subpart B. 42 CFR, 483.15(h)(2) During tour with RN 8 on 7/8/15 at 1415 hours, room D's bathroom was observed with the following unlabeled items: one clear bottle of hair gel on the windowsill, a black electric shaver, and a bottle of cologne. RN 8 verified the items should have been labeled.

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

The above isolated deficiencies pose no actual harm to the residents