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

POC accepted by [signature] 11/29/12

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056760	A. BUILDING _____ B. WING _____	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA HEALTHCARE & WELLNESS CENTRE, LP	415 SOUTH GARFIELD ALHAMBRA, CA 91801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: Surveyor ID#: 17019 Surveyor ID#: 16279 Surveyor ID#: 27785 Total Resident Population: 93 Total Resident Sample: 19 Highest Scope and Severity: E	F 000	Alhambra Healthcare and Wellness Centre submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	
F 153 SS=C	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform the residents of their right to access their medical records. Seven of eight alert and oriented residents indicated they were not made aware of their right to access their medical records	F 153	F 153 483.10(b)(2) Right to Access/Purchase Copies of Records a) The Activities Director handed out the "Resident's Rights" and explained to the residents and responsible party that they have the right to review their own medical records. b) The Activities Director asked other residents and responsible party if they knew that they can review their medical records and gave the "Residents Rights" form.	11/19/12

RECEIVED 2012 NOV 17 PM 4:22 HEALTH SERVICES INSPECTION DIVISION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/29/12

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

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F 153	Continued From page 1 Findings: During the group interview on 10/25/12 at 10 a.m., seven of 8 alert and oriented residents indicated they were not aware of their right to review their own medical records. The residents stated that they were not made aware of this right. The residents stated that it was good to know this right and that they may be interested in reviewing their medical records in the future. During an interview on 10/25/12 at 2 p.m., the administrator stated she will make sure the residents are made aware of this right. The facility's policy and procedures, titled "Resident Access to Financial or Clinical Records", revised January 01, 2012, indicated "Each resident has the right to access his or her financial and clinical records upon request."	F 153	c) The Activity Director will educate new admissions on the "Resident's Rights" and educate them they are able to view their medical records. Activities Director will remind residents monthly of their rights during monthly resident council meeting. d) The Activity Director will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	F164 483.10(e), 483.75(l)(4) Personal Privacy/Confidentiality of Records a) The Director of Staff Development in-serviced the staff to announce themselves after they knock on a residents door. b) The Director of Staff Development will monitor during room rounds the staff is knocking on doors and announcing themselves. c) The Director of Staff Development will conduct random rounds to ensure that the staff is knocking and announcing themselves when entering the resident rooms	11/12/12

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F 164	Continued From page 2 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide personal privacy for three of eight alert and oriented residents who attended the group interview. During the group interview, three of eight residents stated that the staff do not always knock and announce themselves before entering their room, and most of the time when the staff knock on the door, the staff do not wait for the residents to acknowledge and give permission for the staff to enter the room. Findings: During the group interview on 10/25/12, at 10 AM, three of eight alert oriented residents stated that the staff do not always knock and announce themselves before entering their room, and most of the time when the staff knock on the door, the staff do not wait for the residents to acknowledge and give permission for the staff to enter the room. The residents stated that the staff just go right in their room and even after knocking on the	F 164	d) The Director of Staff Development will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	

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F 164	Continued From page 3 door, the staff do not give them time to react. The facility's policy and procedure titled "Resident Rights - Quality of Life" indicated that the staff will knock and request permission before entering residents' rooms. During an interview with the administrator on 10/25/12, at 2 PM, she stated that all the staff will be reminded to respect the residents' privacy and wait for permission to enter their rooms.	F 164		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents were informed of the availability of the annual survey results. Eight out of eight residents who attended the group interview did not know the survey results are available to them for review, and or the location of where the survey results are kept. Findings:	F 167	F 167 483.10(g)(1) Right to Survey Results-Readily Accessibble a) The Activities Director handed out the "Resident's Rights" and explained to the residents and responsible party that the past years survey results are posted on the consumer board near the front of the facility and that they have the right to review the survey results. b) The Activities Director asked other residents and responsible party if they know that they can review the survey results from the last year and gave the "Residents Rights" form. c) The Activity Director will educate new admissions on the "Resident's Rights" and educate them on where the survey results are located and that they are able to view it. Activities Director will remind residents monthly of their rights during monthly resident council meeting.	11/19/12

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F 167	Continued From page 4 During the group interview on 10/25/12 at 10 AM, eight of eight alert and oriented residents stated they were not aware of the availability of and location of the annual survey results. The residents stated that they are interested in reading the facility's annual survey results. During an interview with the administrator on 10/25/12 at 2 PM, she stated that the staff will inform the residents of the availability and location of the annual survey results. The facility's policy and procedure titled "Resident Rights" indicated that the facility will promote and protect the rights of the residents under the state and federal law. Listed among those rights was the right to examine survey results.	F 167	d) The Activity Director will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	
F 168 SS=C	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's staff failed to inform the residents of the available agencies acting as client advocates, such as the Ombudsman's office. Seven of 8 alert and oriented residents stated that they were not aware of such agency. Findings: During the group interview on 10/25/12 at 10	F 168	F 168 483.10 (g)(2) Right to info from/contact Advocate Agencies a) The Activities Director handed out the "Resident's Rights" and explained to the residents and responsible party that the Ombudsman agency is here to support them and that there are 4 Ombudsman signs located throughout the building. b) The Activities Director asked other residents and responsible party if they knew that there was an Ombudsman Agency and gave the "Residents Rights" form.	11/19/12

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F 168	Continued From page 5 a.m., seven of 8 alert and oriented residents indicated they were not made aware of the availability of client advocates, such as the Ombudsman's office. The residents stated that it was good to know that there are available advocate agencies that could help them with unresolved issues in the facility. During an interview on 10/25/12 at 2 p.m., the administrator stated that she will make sure the residents are informed of the availability of client advocate agencies, such as the Ombudsman's office. The facility's policy and procedures titled "Notice of Resident Rights", revised January 01, 2012, indicated that its purpose is "To ensure that residents are fully informed of their rights during their stay at the Facility... The Facility informs the resident both orally and in writing of his or her rights as a resident, of and the rules and regulations governing the resident's conduct and responsibilities during his or her stay in the Facility."	F 168	c) The Activity Director will educate new admissions on the "Resident's Rights" and educate them there is an Ombudsman Agency. Activities Director will remind residents monthly of their rights during monthly resident council meeting. d) The Activity Director will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically-related social services	F 250	F 250 483.15(g)(1) Provision of Medically related Social Service a) Social Services Designee completed the initial social services assessment on Resident 5. 10/29/12 b) Medical records did an audit to verify no additional residents were missing initial social services assessments.	11/20/12

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F 250	Continued From page 6 to one (Resident 5) of 19 sample residents. The resident had been in the facility for 10 days and had not been assessed by the social services department for medically-related social services needs. Findings: According to the admission information, Resident 5 was admitted to the facility on 10/19/12 with diagnoses that included Alzheimer's disease (an irreversible, progressive brain disease that slowly destroys memory and thinking skills and eventually even the ability to carry out simplest tasks), end-stage renal (kidney) disease and dysphagia (difficulty in swallowing). The Minimum Data Set (MDS), a standardized assessment and care planning tool dated 10/26/12, indicated the resident had cognitive (mental) impairments and required extensive assistance with daily activities such as personal hygiene and bathing. On 10/29/12 at 10 a.m., a review of the resident's clinical records revealed that the social services assessment had not been done. During an interview on 10/29/12 at 10:40 a.m., the social services designee (SSD) stated that she has not done the social services assessment yet. The SSD acknowledged that it should have already been done, realizing that today is the resident's 10th day in the facility. The SSD stated that she will do the assessment today as soon as possible. The facility's policy and procedures, titled "Social Service Assessment", revised January 01, 2012,	F 250	c) Social Services Designee was in-serviced by the Social Worker consultant regarding the Initial Assessments. Medical Records will audit the charts monthly for initial social services assessments. d) Medical Records Designee will report any negative findings to the Administrator and will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	

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F 250	Continued From page 7 indicated "The Director of Social Services or his or her designee will complete a Social Services Assessment for new residents within seven (7) days of admission. The Social Services Assessment will address the resident's physical and psychosocial limitations that need to be addressed in developing the resident's activity plan."	F 250		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain the noise at a level that would not interfere with the residents' comfort especially when they are asleep, for 3 out of 8 residents in the group interview, which resulted in a loss of needed sleep and rest for the residents. Findings: During a group interview on 10/25/12 at 10 AM, 3 out of 8 residents who attended the meeting stated that the noise level, especially during the early morning hours around 5 AM, would wake them up. The residents stated that staff talk among themselves with loud voices. The residents further stated that they brought this concern to the staffs' attention but the staff talking loudly had not resolved. A review of an undated policy titled "Resident	F 258	F 258 483.15(h)(7) Maintenance of Comfort Sound Levels a) The Director of Staff Development in-serviced the staff to provide safe clean home-like environment. b) The Director of Staff Development will monitor for comfortable noise level during room rounds and elevate unnecessary background noises. Implantation of minimum overhead paging and loud talking especially in the early morning hours. c) The Director of Staff Development and/or Director of Nursing will conduct random rounds to ensure that the staff is speaking at a comfortable home-like environment level.	11/12/12

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F 258	Continued From page 8 Rooms and Environment", indicated it is the facility's policy to provide residents with a safe, clean, comfortable, and homelike environment, and that staff will provide residents with a pleasant environment and person centered care that emphasizes the residents' comfort, independence, and personal needs. The policy also indicated that the facility staff will aim to create a personalized, homelike atmosphere, paying close attention to comfortable noise level among others. During an interview with the administrator on 10/25/12, at 2 PM, she stated that the facility have been emphasizing a comfortable noise level in the facility and have minimized overhead paging for that reason. The administrator said she would address the issue of talking loudly among staff.	F 258	d) The Director of Staff Development and/or Director of Nursing will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the correct dose of medication was administered to a resident as was ordered by the physician. Resident 7 had a physician's order to be	F 309	F 309 483.25 Provide/Care Services for Highest Well Being a) DNS (Director of Nurse) called physician immediately to clarify the MVI with minerals from 5 ml to 15 ml. The MAR was immediately updated and LN administered the medication as ordered to ensure Resident 7 is receiving the optimum dose of MVI with minerals.10/24/12	10/24/12

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F 309	Continued From page 9 administered 15 milliliters (ml) of multivitamins with minerals (MVI) once daily. However, the resident was being given 5 ml of MVI with minerals instead. This resulted in the resident not receiving the optimum dose of MVI and minerals as the resident was determined to need. Findings: A review of the admission record for Resident 7 indicated she was originally admitted to the facility on 6/17/12, and was readmitted on 7/3/12, with diagnoses that included osteoporosis (disease leading to reduced bone mineral density and altered amount and variety of proteins in bone, (which increases risk for fracture), dysphagia (difficulty to swallow), Alzheimer's disease (an irreversible, progressive brain disease that slowly destroys memory and thinking skills and eventually even the ability to carry out simplest tasks), and muscle disuse atrophy (loss in the mass and strength of the muscle due to inactivity). The latest minimum data set (MDS), a standardized assessment and care planning tool), dated 10/8/12, indicated Resident 7 did not have the ability to make self understood and understand others. The resident's cognitive (mental) skills for daily decision making were severely impaired, and she was totally dependent on staff for most of her activities of daily living. The MDS also indicated that the resident was being fed through a gastric tube (GT), did not have any history of weight loss, was at risk of developing pressure ulcers, and used oxygen therapy.	F 309	b) The DNS and ADON audited in-house residents with liquid MVI with minerals and called physician to clarify orders of MVI with minerals from 5 ml to 15 ml if needed. To ensure residents is receiving the optimum dose of MVI with minerals. 10/24/12 c) The DNS/DSD (Director of Staff Development) will provide in-service to LN staff on Medication-Administration policy with focus on ensuring that liquid MVI with minerals to be ordered at 15ml for residents to receive the optimum dose of MVI with minerals. MRD will also be in-serviced on accuracy when entering orders and clarifications as needed The LN (License Nurse) will monitor and review resident physician order daily during med pass and monthly during recap process to ensure that liquid MVI with minerals is order at the appropriate dose to ensure resident is receiving the optimum dose.	

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F 309	Continued From page 10 The September and October 2012 recapitulation of the physician orders for Resident 7 indicated there was a physician order dated 7/20/12, to give 15 ml of MVI with mineral via GT daily. However, during the 9 AM medication pass observation on 10/24/12, the charge nurse for Station 2 was observed to give Resident 7 5 ml of MVI with minerals instead of 15 ml as the physician ordered. The medication administration record (MAR) for the month of October 2012, indicated Resident 7 was being given 5 ml of MVI with minerals instead of 15 ml as ordered, for 24 days, from 10/1/12 to 10/24/12. During an interview with the assistant director of nursing (ADON) on 10/25/12, at 9:15 AM, she stated that the recapitulation of physicians order was correct and that the nurses were supposed to give the resident 15 ml of the MVI with minerals as recommended by the registered dietician (RD) and as ordered by the physician. During an interview with the charge nurse on 10/25/12 at 1:50 PM, she stated that the nurses have been giving 5 ml of the MVI with minerals. Additionally, after clarifying the MVI with minerals order, the charge nurse stated that the nurses were supposed to give the resident 15 ml MVI with minerals as ordered. The charge nurse further stated the staff will update the MAR.	F 309	The MRD will review orders upon admission and new telephone orders and will return orders to nursing for clarification as needed. Pharmacy Consultant will review orders during monthly visits and will forward report to DNS and Administrator to corrective action. d) The DNS or designee will provide a summary trend analysis of negative findings to the CQI Committee for further recommendation and re-evaluation during regularly scheduled meetings.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328		

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	055760	A. BUILDING _____ B. WING _____	10/31/2012

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F 328	Continued From page 11 injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that one (Resident 7) of 19 sampled residents was being administered the correct amount of oxygen (O2) as ordered by the physician. Resident 7, who had a physician order for continuous O2 inhalation at 2 liters per minute (LPM) via nasal cannula (NC), was observed on two separate occasions receiving more than 2 liters per minute. This had the potential for the resident to develop oxygen toxicity (oxygen overdosage.) Findings: During the initial tour with the admissions coordinator on 10/23/12, at 2 PM, Resident 7 was observed in her room, asleep in her bed. The resident was on continuous O2 inhalation at a flow rate of 3.5 LPM via NC. This was observed with the admission coordinator. The resident was not showing any sign of shortness of breath. During the medication pass observation, on 10/24/12/ at 9:20 AM, Resident 7 was observed in her room awake in her bed. The resident was on continuous O2 inhalation at a flow rate of 3 LPM	F 328	F 328 483.25(k) Treatment/Care for Special Needs a) Resident 7 oxygen (O2) order was clarified and the LN administrated the O2 as order. There was no sign and symptom of adverse effects. No negative outcomes noted. 10/25/12 b) The LN staff conducted rounds on residents with O2 to review the administered dose of O2 per physician order. No other issues identified. LN staff reviewed the MAR's for in-house resident to ensure no others orders required clarification. c) The DNS/Designee will provide in-service to the LN staff on policy and procedure of administrating O2 with the focus on O2 administration per physician order. The LN's will monitor for O2 compliance during rounds daily and will correct identified issues as needed to ensure O2 is administered per physician order. d) The DNS or designee will provide a summary trend analysis of negative findings from LN and DNS review of Oxygen administration to the CQI Steering Committee for further recommendation and re-evaluation.	10/25/12

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F 328	Continued From page 12 via NC as verified with the medication nurse for station 2. A review of the admission record for Resident 7 indicated she was originally admitted to the facility on 6/17/12, and was readmitted on 7/3/12, with diagnoses that included osteoporosis (disease leading to reduced bone mineral density and altered amount and variety of proteins in the bone), dysphagia (difficulty to swallow), Alzheimer's disease (an irreversible, progressive brain disease that slowly destroys memory and thinking skills and eventually even the ability to carry out simplest tasks), and congestive heart failure (CHF, a condition in which the heart cannot pump enough blood to the rest of the body). The latest minimum data set (MDS), a standardized assessment and care planning tool), dated 10/8/12, indicated Resident 7 did not have the ability to make self understood and understand others. The MDS indicated that the resident's cognitive (mental) skill for daily decision making was severely impaired, was totally dependent on staff for most of her activities of daily living, was being fed through a gastric tube (GT), did not have any history of weight loss, was at risk of developing pressure ulcers, and used O2 therapy. A physician's order for Resident 7 dated 7/3/12 and 9/20/12, indicated to administer O2 inhalation continuously at a rate of 2 LPM via NC for CHF and shortness of breath. A care plan for the use of oxygen dated 9/20/12, indicated Resident 7 used O2 inhalation at 2 LPM	F 328		

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F 328	Continued From page 13 via NC and was at risk for complications related to oxygen toxicity. The care plan approach/plan listed to maintain O2 flow rate and concentration as ordered. During an interview with the director of nursing (DON) on 10/25/12 at 9:30 AM, she stated that the reason that Resident 7's O2 setting was sometimes above the ordered rate was because they were titrating the resident's oxygen saturation ((O2 sat) a measure of the amount of oxygen carrying hemoglobin in the blood], to be at or above 92 percent (%). The DON acknowledge that O2 inhalation at 3 or 3.5 LPM, was not ordered by the physician and further stated she would call the resident's physician and obtain a new order to allow for adjustment of the O2 setting to more than 2 LPM to titrate the O2 sat at or above 92%. A review of the facility's undated policy and procedure, titled "General Policies and Guidelines", indicated that the administration of oxygen and respiratory medication and procedures require a physician's order.	F 328		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to ensure that it	F 332	F 332 483.25(m) Free of Medication Error Rates of 5% or More A) a and b) One to one in-service was done to LN 1 on shaking liquids medication prior dispensing medication to residents 20 and resident 12 to ensure liquid medication to distribute evenly prior to administrating for resident to receive the optimum dose. 10/24/12	10/24/12

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F 332	Continued From page 14 was free of a medication error rate of 5 percent or greater, as evidenced by the identification of 4 medication errors out of 53 opportunities for errors, to yield a facility medication error rate of 7.6 percent. Findings: a. On 10/24/12 at 8:22 a.m., a licensed nurse (LVN 1) was observed as she prepared and administered a randomly-selected resident's (RS 20) morning medications via gastrostomy tube (G-tube, a tube inserted through a small incision in the abdomen into the stomach and is used for long-term nutrition and medication administration). Upon preparation of the resident's liquid medication Colace, LVN 1 failed to shake the bottle before pouring the dose. The Colace bottle label indicated to shake well prior to use. This accounted for one medication error. b. On 10/24/12 at 9 a.m., LVN 1 was observed as she prepared Resident 12's morning medications via G-tube. LVN 1 failed to shake the bottle of liquid multivitamins with minerals. The multivitamins with minerals bottle label indicated to shake well prior to use. This accounted for one medication error. During an interview on 10/24/12 at 10:23 a.m., LVN 1 acknowledged her failure to shake the medication bottles prior to pouring the dose. LVN 1 stated that shaking the bottles would distribute the medications evenly, which will help prevent underdosing or overdosing the residents. c. During a medication pass observation on	F 332	c) DNS called physician immediately to clarify the MVI with minerals from 5 ml to 15 ml. The MAR was immediately updated and LN administered the medication as ordered to ensure Resident 7 is receiving the optimum dose of MVI with minerals.10/24/12 d) The ADON called physician immediately to clarify the Albuteral Sulfate 2.5 mg per 0.5 ml vial to Albuteral Sulfate 2.5 mg per 3 ml vial via inhalation with mask. Physician order Albuteral Sulfate Q 6hr as needed for 2 weeks than discontinued. Informed phsician of resident Albuteral Sulfate dosages currently use and there was no sign and symptom of adverse effects. No negative outcomes noted. 10/24/12 B) DNS/DSD in-serviced LN on medication administration with the focus on liquids medication. Ensuring liquids medication to be shaken well prior to dispensing for residents to receive the optimum dose. 10/24/12 C) The DNS and ADON audited in-house residents with liquid MVI with minerals and called physician to clarify orders of MVI with minerals from 5 ml to 15 ml if needed. To ensure residents is receiving the optimum dose of MVI with minerals. 10/24/12	

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F 332	Continued From page 15 10/24/12 at 8:30 AM, the medication nurse for Nurse Station 2 was observed as she prepared and administered the medications of Resident 7 via gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition and medication directly to the stomach). The medication nurse for Nurse Station 2 gave the resident 5 milliliters (ml) of multivitamin with minerals. However, a review of the September and October 2012 recapitulation of physician orders indicated there was a physician order dated 7/20/12, to administer 15 ml of multivitamins with mineral via GT daily, not 5 ml as the medication nurse administered. During an interview with the assistant director of nursing (ADON), on 10/25/12, at 9:15 AM, the DON stated that the recapitulation of physicians order was correct and that the resident was supposed to be administered 15 ml of multivitamins with minerals as recommended by the registered dietician (RD) and as ordered by the physician. During an interview with the medication nurse for Nurse Station 2, on 10/26/12, at 1:50 PM, she stated that the staff had been giving the resident 5 ml of multivitamins with minerals. The medication nurse after clarifying the order, stated that the resident was supposed to be given 15 ml of multivitamins with minerals as ordered. The medication nurse stated the staff will update the medication administration record (MAR). The facility's undated policy titled "Medication-Administration" indicated that	F 332	The LN staff reviewed the MAR's for in-house residents with Albuerol Sulfate to ensure no others required clarification. 10/25/12 D) The DNS/DSD will provide in-service to LN staff on Medication-Administration policy with focus on medications and treatment will be administered as prescribe to ensure compliance with dose guidelines and on ensuring that liquid MVI with minerals to be ordered at 15ml for residents to receive the optimum dose of MVI with minerals. MRD will also be in-serviced on accuracy when entering orders and clarifications as needed. 10/24/12 The LN will review in house residents physician orders daily during med pass and monthly during recap process ensure medication will be administered as prescribed to ensure compliance with dose guidelines. The MRD will review orders upon admission and new telephone orders and will return orders to nursing for clarification as needed. Pharmacy Consultant will review orders during monthly visits and will forward report to DNS and Administrator to corrective action.	

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F 332	Continued From page 16 medication and treatments will be administered as prescribed to ensure compliance with dose guidelines. d. During a medication pass observation on 10/24/12, at 8:30 AM, the medication nurse for Nurse Station 2 was observed as she prepared and administered the medications of Resident 7. After giving the resident's medication via gastrostomy tube the medication nurse for Nurse Station 2 gave Albuterol sulfate 2.5 milligrams (mg) per 3 milliliter (ml) vial via inhalation with a mask that was ordered every four hours for the resident's breathing treatment. However, a review of the September and October 2012 recapitulation of physician orders for Resident 7 indicated there was a physician order dated 7/13/12, to give Albuterol sulfate 2.5 mg per 0.5 ml vial, not 3 ml vial as was administered, via inhalation with a mask every four hours. During an interview with the medication nurse for Nurse Station 2, on 10/26/12, at 1:50 PM, she stated that Albuterol sulfate 2.5 mg per 3 ml vial was what the staff had been using and which came from pharmacy. The facility's undated policy titled "Medication-Administration" indicated that medication and treatments will be administered as prescribed to ensure compliance with dose guidelines.	F 332		
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		

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F 371	Continued From page 17 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and protect food under sanitary conditions, regarding one refrigeration unit with a torn gasket and possible food contamination. Findings: On October 29, 2012 7:05 a.m., during the kitchen observation, the the following were noted: 1. There were four refrigeration units throughout the kitchen. Upon closer observation, the True freezer had torn gaskets on two of two doors (A gasket is the rubber seal, on the interior of the refrigeration unit, which insulates and keeps the cool air inside the unit.). This freezer had an internal temperature -10 degrees Fahrenheit. 2. There was an opened 1-gallon container of cleaning detergent that was on a countertop, 6 inches away from a rice cooker, which was in the cooking process. Closer observation revealed that the cleaning detergent's label stated, "Harmful if swallowed." This opened cleaning detergent could lead to a possible food contamination.	F 371	F371 483.35(i) Food Procure, Store/Prepare/Serve- Sanitary a) The Maintenance Supervisor replaced the True freezer gaskets that were torn on two doors. The open 1-gallon container of cleaning detergent on the countertop that was located 6 inches away from the rice cooker was removed immediately. b) Dietary Supervisor in-serviced dietary staff to report any torn freezer gasket and to not place any cleaning detergent around that may cause food contamination. c) Dietary Supervisor will monitor the freezer gaskets for any tears on a periodic basis and for any cleaning detergents that might be in the kitchen causing contamination. d) The Dietary Supervisor will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	11/20/12

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F 371	Continued From page 18 On October 29, 2012, at 9:25 a.m., during an interview with the dietary supervisor, the torn gaskets and cleaning detergent were brought to the dietary supervisor's attention. The dietary supervisor stated that she would correct these problems, immediately.	F 371	F 425 483.60(a)(b) Pharmaceutical SVC-Accurate Procedures , RHP a) The Injectable Emergency Kit of medication that had not been replenished was replaced on the day of discovery.	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to ensure that one (Resident 7) of 19 sample residents was administered the correct medications that the physician ordered. The facility also failed to	F 425	The ADON called physician immediately to clarify the Albuteral Sulfate 2.5 mg per 0.5 ml vial to Albuteral Sulfate 2.5 mg per 3 ml vial via inhalation with mask. Physician order Albuteral Sulfate Q 6hr as needed for 2 weeks than discontinued. Informed physician of resident Albuteral Sulfate dosages currently use and there was no sign and symptom of adverse effects. No negative outcomes noted.10/25/12 b) DNS and ADON conducted a reviewed audit of the facility Emergency Kits to ensure that it has been replaced in a timely manner. 10/23/12 The LN staff reviewed the MAR's for in-house residents to ensure no others required clarification. 10/25/12 c) The DSD/DNS provided in-service re-education regarding medications removal and replacement of Emergency Kits. 10/23/12	10/25/12

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F 425	Continued From page 19 ensure that emergency medications were available. The injectable emergency kit (E-kit) had not been replenished. Findings: a. An inspection of Station 1's medication room on 10/23/12 at 2:25 p.m. revealed the injectable E-kit was opened on 10/9/12 (14 days ago) with Kayexalate 15 Gm removed and used for a resident. According to the licensed nurse, the pharmacy had already been made aware of the need to replace the E-kit. The licensed nurse stated that a pharmacy staff had just come to the facility earlier this morning but did not deliver a replacement for the used injectable E-kit. Pursuant to California Code of Regulations, Title 22, Section 72377(b)(2), drugs used from the emergency kit shall be replaced within 72 hours and the supply resealed by the pharmacist. b. A review of the admission record for Resident 7 indicated she was originally admitted to the facility on 5/17/12, and was readmitted on 7/3/12, with diagnoses that included osteoporosis (disease leading to reduced bone mineral density and altered amount and variety of proteins in bone which increases risk for fracture), dysphagia (difficulty to swallow), Alzheimer's disease (an irreversible, progressive brain disease that slowly destroys memory and thinking skills and eventually even the ability to carry out simplest tasks), and muscle disuse atrophy (loss in the mass and strength of the muscle due to inactivity). The latest minimum data set (MDS), a	F 425	The LN's will review the expiration date of Emergency Kits and re-order them for replacement as needed. 10/23/12 The DNS or designee will monitor for compliance via weekly checks of Emergency Kits. 10/23/12 The DNS/DSD will provide in-service to LN staff on Medication-Administration policy with focus on medications and treatment will be administered as prescribe to ensure compliance with dose guidelines. MRD will also be in-serviced on accuracy when entering orders and clarifications as needed The LN will review in house residents physician orders daily during med pass and monthly during recap process ensure medication will be administered as prescribed to ensure compliance with dose guidelines. The MRD will review orders upon admission and new telephone orders and will return orders to nursing for clarification as needed. Pharmacy Consultant will review orders during monthly visits and will forward report to DNS and Administrator to corrective action.	

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F 425	Continued From page 20 standardized assessment and care planning tool, dated 10/8/12, indicated Resident 7 did not have the ability to make self understood and understand others. The MDS also indicated that the resident's cognitive (mental) skills for daily decision making were severely impaired, was totally dependent from staff for most activities of daily living, was being fed through a gastric tube (GT), did not have any history of weight loss, was at risk of developing pressure ulcers, and used oxygen therapy. The September and October 2012 recapitulation of physician orders for Resident 7 indicated there was a physician's order dated 7/13/12, to give Albuterol sulfate 2.5 milligram (mg) per 0.5 milliliters (ml) vial via inhalation with a mask every four hours. However, during the 9 AM medication pass observation on 10/24/12, the charge nurse for Station 2 was observed to give Resident 7 Albuterol sulfate 2.5 mg per 3 ml vial via inhalation with a mask. The medication administration record (MAR) for the month of October 2012, indicated Resident 7 was being administered Albuterol sulfate 2.5 mg per 0.5 ml vial via inhalation with a mask. However, during an interview with the medication nurse for Nurse Station 2 on 10/25/12, at 1:50 PM, she stated that the Albuterol sulfate 2.5 mg per 3 ml vial was what the staff had been using which came from pharmacy. The facility's undated policy titled "Medication-Administration" indicated that medication and treatments will be administered	F 425	d) The DNS or designee will provide a summary trend analysis of negative findings from LN and DNS review of medication to the CQI Steering Committee for further recommendation and re-evaluation.	

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	055760	A. BUILDING _____ B. WING _____	10/31/2012

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F 425	Continued From page 21 as prescribed to ensure compliance with dose guidelines.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F 441 483.65 Infection Control, Prevent spread, Linens A) a) LVN removed the gloves and used new ones and washed her hands after administration of medications via G-tube and inhaler medications for resident. 10/25/12 b) DSD contacted medical director regarding missing physical and made an appointment for employee who had a missing physical. B) a) Director of Nursing did a one on one in-service with the LVN regarding the policy and procedures of "Hand Hygiene" DSD monitored the nursing staff to ensure that proper hand washing techniques and changing of gloves were used. 10/25/12 b) DSD conducted and audit of employees to ensure that there is a physical and TB test for all employees.	10/25/12

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F 441	Continued From page 22 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's staff failed to provide a safe and sanitary environment to one randomly-selected resident (RS 20). The facility also failed to ensure that tuberculosis screening was done to one newly-hired employee. Findings: a. On 10/24/12 at 8:22 a.m., a licensed nurse (LVN 1) was observed as she administered a randomly-selected resident's (RS 20) morning medications via gastrostomy tube (G-tube). LVN 1 also administered the resident's inhaler and handled the bottle of sublingual drops after the G-tube procedure. After handling the resident's G-tube and administering the resident's medications via G-tube, LVN 1 proceeded to handle and administer the resident's inhaler (puffer) medication using the same pair of soiled gloves (which were potentially contaminated). After the inhaler, LVN 1 then handled the resident's bottle of sublingual medication (Immunocal). During an interview on 10/25/12 at 10:23 a.m., LVN 1 acknowledged her failure to remove the gloves and clean her hands after handling the G-tube and before handling and/or administering the inhaler and sublingual medication.	F 441	C) a) Director of Nursing and/or DSD will conduct random rounds to ensure that the nursing staff removes gloves and that proper "Hand Hygiene" policies are being met. b) DSD will use the new employee check list and audit it monthly to ensure that physicals and TB test were completed. D) The Administrator and/or Director of Nursing will report any negative findings. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	

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	056760	A. BUILDING _____ B. WING _____	10/31/2012

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F 441	Continued From page 23 The facility's policy and procedures, titled "Hand Hygiene", revised January 01, 2012, indicated "In most situations, hand hygiene is with an alcohol-based hand rub is acceptable. If hands are not visibly soiled, an alcohol-based hand rub containing 60-95% ethanol or isopropanol may be used for all the following situations:.. F. Before moving from a contaminated body site to a clean body site during resident care; G. After contact with a resident's intact skin; H. After handling used dressings, contaminated equipment, etc.; I. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and J. After removing gloves." b. On October 30, 2012, at 1:30 p.m., the evaluator reviewed six newly employee files, who were hired between August 13, 2012 and October 15, 2012. One of the six employees was hired, on September 2, 2012, but did not have a physical examination and a TB skin test. The five other employee files had physical examination forms completed and signed by physicians. And these five employee files also had documentation that TB skin tests were conducted with the results for TB screening. On October 30, 2012, at 2:40 p.m., the evaluator conducted an interview with the staff developer (SD) regarding this one employee file that was missing a physical examination and TB skin test. During this interview, the SD stated this employee should have had a physical examination and TB skin test, upon hire. The SD added that she would contact the employee's previous employer to obtain the employee's results of the physical examination and the TB skin test results. On October 30, 2012, at 3:26 p.m., a review of	F 441		

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F 441	Continued From page 24 the facility's policy and procedure for employee physical examinations indicated that the law requires that all employees have a physical examination and TB skin test on file with the facility within seven (7) days of employment.	F 441		
F 457 SS=B	483.70(d)(1)(i) BEDROOMS ACCOMODATE NO MORE THAN 4 RESIDENTS Bedrooms must accommodate no more than four residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that resident bedrooms accommodate no more than four residents in 1 of 47 resident rooms. Room 16 had five beds inside this resident room. Findings: On October 23, 2012, between 1:35 p.m. and 2:25 p.m., during the initial tour, the evaluator observed that one of the 47 resident bedrooms had five resident beds in Room 16. Closer observations showed that the rooms had space for the beds and dressers, and for the residents to ambulate inside the rooms. The evaluator also noticed that the nursing staff had enough space to provide care to the residents, the privacy curtains provided privacy for each resident and the room had a door with direct access to the corridor. On October 23, 2012, at 3:15 p.m., the evaluator conducted an interview with the administrator who stated that she would submit a room waiver.	F 457	F 457 483.70(d)(1)(i) Bedroom Accommodate no more than 4 residents a) The Administrator wrote to CMS and the DHS a letter to request a Room Waiver (previously approved already) b) The Administrator reviewed the floor plan and found no other rooms to have more than 3 residents per room. c) The Administrator will follow up with DHS and CMS to obtain and approval for the Room Waiver d) The Administrator will report any negative findings. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	10/29/12

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F 457	Continued From page 25 On October 29, 2012, at 11:15 a.m., the administrator submitted a waiver for the five bed resident room. A review of this wavier indicated that these bedrooms were of the original construction and that the residents' health, safety and comfort would not have an adverse effect on the residents.	F 457		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for the residents, regarding two of four unsecured shower drain covers. Findings: On October 23, 2012 between 1:35 p.m. and 2:25 p.m., the evaluator observed four resident shower rooms throughout the facility. Upon closer observation, the evaluator noticed that the shower drain covers were 3-inches in diameter. On October 24, 2012, between 8:35 a.m. and 10:59 a.m., the evaluator conducted a general observation with the maintenance supervisor. At 9:42 a.m., the evaluator observed that the shower room next to Room 4 had an unsecured shower drain cover. At 9:57 a.m., the evaluator observed	F 465	F 465 483.70(h) Safe/Functional/Sanitary/Comfortable Environment a) The Maintenance Supervisor secured the shower drains next to room 4 and 47. b) The Maintenance Supervisor checked the shower drains throughout the facility and secured all the shower drains. c) The Maintenance Supervisor will conduct a monthly check of all shower drains to ensure that they are secured so that no accidents occur. d) The Maintenance Supervisor will will report any negative findings to the Administrator. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance	10/24/12

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F 465	Continued From page 26 that the shower room next to Room 47 had an unsecured shower drain cover. On October 24, 2012, at 11:05 a.m., the evaluator conducted an interview with the maintenance supervisor regarding these two shower rooms with unsecured shower drain covers. At this same time, the maintenance supervisor was shown the two unsecured shower room drain covers. The evaluator mentioned that the unsecured shower drain covers were unsafe if residents are transported into the shower room, using a shower chair, a wheel might enter the unsecured shower drain covers that could cause the shower chair to tip over, the resident could fall down and be injured. The maintenance supervisor stated he would secure the shower drain covers, immediately.	F 465		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain laboratory services to meet the needs of a resident as the physician ordered for one of 19 sample residents (9). Findings: A review of the Face Sheet of indicated Resident 9 was admitted to the facility on 4/13/06, with diagnoses that included hypertension (high blood	F 502	F 502 483.75(j)(1) Administration a) DNS called the physician to informed him that there were no lab results for lipid panel for July 2012. There was order for CBC and lipid panel every 6 months. Lab result for CBC was is in the chart and there was a refusal lab result present in the chart that can be the lipid panel test result. RN supervisor provided the late entry documentation regarding resident refusal to get lab draw. b) All resident have the potential to be affected.	10/29/12

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F 502	Continued From page 27 pressure), hemiplegia of dominant side (paralysis of one side of the face and the opposite side of the body), chronic obstructive bronchitis (chronic inflammation of the medium-size airways in the lungs), and diabetes mellitus (condition that occurs when the body can not use glucose normally which causes glucose levels in the blood to rise.) The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 8/14/12, indicated the resident had the ability to make self understood and understand others. The resident required extensive assistance from staff for bed mobility and personal hygiene, and was totally dependent for dressing and toilet use. The recapitulation of physician orders for the month of September and October 2012 indicated there was a physician's order dated 7/19/05, to obtain a fasting lipid panel (a laboratory [lab] blood test that measures lipids, cholesterol, and lipoproteins in the body) every January and July due to hypercholesterolemia (presence of high levels of cholesterol in the blood). However, a review of the clinical record revealed there was no lab test result for a fasting lipid panel for the month of July 2012. Additionally, there was no documented evidence of the fasting lipid panel being done or the reason why the fasting lipid panel had not been done. During an interview with the director of nursing (DON) on 10/29/12, at 3:26 PM, she stated the staff could not find a result for a lipid panel lab test for July 2012. The DON said the staff called the lab and the lab did not have any record of the lipid panel test result. The DON said the lab did	F 502	In-service LN regarding obtaining lab result on a timely manner and placed them in the clinical record. Notify physician of resident refusal of lab draw and provide documentation regarding resident refusal of lab draw. c) The assigned Desk Nurse will ensure that labs are drawn and obtained and placed in the clinical record. Night shift LN will document resident refusal of lab draw and informed physician. The assigned Desk Nurse will report any concerns to DNS of any concerns or follow-ups Diagnostic Lab consultant will review and audits during monthly visits and will forward report to DNS and Administrator to corrective action. d) The DNS or designee will provide a summary trend analysis of negative findings to the CQI Committee for further recommendation and re-evaluation during regularly scheduled meetings	

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F 502	Continued From page 28 not know if the fasting lipid panel test was or was not done or why the test was not done. According to the facility's undated policy and procedure titled "Laboratory Services", the facility will provide laboratory services when ordered by the physician, and maintain the order for the lab and the results in the resident's medical record.	F 502		
F 518 SS=E	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 interview and record review, the facility failed to train the staff on the facility's emergency procedures, which could delay the staffs' response time. Four of six staff did not know the facility's emergency generator would provide electricity to the red electrical outlets (during a power outage), the facility's fire code, and the location of the gas shut-off valve. Findings: On October 23, 2012, at 2:30 p.m., the evaluator reviewed the facility's disaster manual. This manual indicated that the facility's emergency generator would provide electricity to the red electrical outlets (during a power outage), the facility's fire code was "Dr. Firestone," and the gas shut-off valve was located at the south side	F 518	F 518 483.75(m)(2) Train all staff-emergency procedures/drills a) The DSD educated the four nursing staff regarding where the emergency generator was, the location of the gas shut off valve, and what the fire code was. 10/24/12 b) The DSD in-serviced the staff regarding Emergency procedure for the facility (Location of emergency generator and gas shut off valve and fire code) 11/15/12 c) The DSD will conduct random rounds monthly and interview the staff to ensure that the staff understands Emergency procedures for the facility. d) The Director of Staff Development and/or Director of Nursing will report to the Administrator of any negative findings and log the corrections. The Administrator will monitor for compliance. Any Trends or negative findings will be reported to the CQI Steering Committee for any recommendations for ongoing compliance.	11/15/12

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F 518	Continued From page 29 of facility. On October 23, 2012 at 3:05 p.m., a 3 p.m. to 11 p.m. shift certified nursing assistant (CNA) did not know what to do during a power outage. The CNA stated that he would do what the charge nurse told him to do. On October 24, 2012 at 6:15 a.m., an 11 p.m. to 7 a.m. shift registered nurse (RN) did not know the emergency generator would provide electricity to the red electrical outlets and that the gas shut-off valve was located at the south side of facility. On October 24, 2012 at 6:45 a.m., an 11 p.m. to 7 a.m. shift CNA stated that the fire code was "Code Red." On October 29, 2012 at 9:50 a.m., a 7 p.m. to 3 p.m. shift RN did not know the fire code and did not know the location of the gas shut-off valve. On October 31, 2012 at 10:15 a.m., the evaluator conducted an interview with the staff developer regarding the emergency procedure staff interviews. During this interview, the staff developer was informed that four of six staff did not know some of the emergency procedures. The staff developer stated all the staff would be in-serviced on the facility's emergency procedures, as soon as possible.	F 518		