POC received & accepted 08/02/12

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

PRINTED: 07/25/2012
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
	055247	A. BUILDING _____ B. WING 2012 AUG -3 PM 2:50	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

(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 #27680 Surveyor ID #19561 Surveyor ID #07598 Total Resident Population: 69 Total Resident Sample Size: 15 Highest Severity and Scope: E	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that grievances brought up by the residents are resolved in a timely manner. During the group interview, one of eight alert and oriented residents who attended the group meeting and one sampled resident complained that the staff from the 11 p.m. to 7 a.m. shift do not promptly answer their call lights. The residents complained that they had to wait over 30 minutes at times for the staff to respond when they needed assistance. This issue was brought up during the previous resident council meeting	F 166	**What corrective action has been accomplished for the identified resident?** Upon discovery on 7-11-12 an all staff in-service which included the 11pm to 7am nursing staff was conducted by the Director of Nursing on the importance of answering call lights timely. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Call lights will be monitored by Administrator, Director of Nurses and Director of Staff Development to ensure they are being answered timely.	8-4-12

2012 AUG -3 PM 2:50

RECEIVED
2012 OCT 25 AM 9:59
HEALTH FACILITIES
INSPECTION DIVISION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		8/3/12

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 166	Continued From page 1 but was not resolved. Findings: During the group interview conducted on July 11, 2012, at 11:10 a.m., one of eight alert and oriented residents who participated stated that she had to wait 30 to 45 minutes for the nursing staff to respond to her call light and attend to her needs during the 11 p.m. to 7 a.m. shift. The resident stated this issue was identified during one of the monthly resident council meetings, but the problem is still ongoing. During a confidential interview on July 11, 2012, at 4 p.m., one sampled resident also complained that the staff from 11 p.m. to 7 a.m. shift would sometimes take over 30 minutes to answer her call light and respond to her needs. The resident stated that the facility is already aware of the the problem and the issue is slowly getting better. A review of the resident council meeting minutes for the month of May 2012, indicated the residents had complained that the call lights were not being answered promptly. During an interview with the director of nursing (DON) on July 13, 2012, at 10:40 a.m., she stated that they are aware of this issue and had given the staff an inservice on responding to the residents' call lights promptly. The DON further stated that the facility periodically conducts random spot checks during all shifts and times the amount of time it takes the staff to respond to the call light. A review of the the facility's policy and procedure	F 166	All staff, has been educated on the importance of answering call lights and not walking past one that is on. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** All staff, not just nursing, is expected to answer call lights. Staff was in-serviced on prior to 7/11/2012 on the importance of answering call lights timely. **What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** Tracking and trending of call lights will be conducted by the Administrator, DON and DSD. Results will be discussed in QA Committee meeting every month.	

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F 166	Continued From page 2 titled "Answering the Call Light" dated September 2003 indicated the purpose of the procedure is to respond to the resident's requests and needs. The procedure indicated to answer the resident's call as soon as possible and be courteous in answering the resident's call.	F 166		
F 253 SS=D	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: Based on observation, and interview, the maintenance staff failed to ensure that the hand wash sink in the bedroom of residents 6 and 7, was working properly. Findings: During an environmental tour of the facility on July 10, 2012, at 4:10 p.m., the hand sink in the bedroom of residents 6 and 7 was observed leaking water under the sink from the "U" shaped pipe into a trash can whenever the valve was turned on. During an interview with the administrator, on July 10, 2012, at 4:25 p.m., he stated he would have the maintenance staff repair the leak. During another observation of the same sink the next day on July 11, 2012, at 3:17 p.m., a new "U": shaped pipe was installed but the water was still leaking under the sink when the valve was	F 253	**What corrective action has been accomplished for the identified resident?** Upon discovery on 7-10-12 the U shaped pipe for the hand sink in the bedroom of residents 6 and 7 was replaced which still leaked on 7-11-12 and was successfully repaired with no leaks on 7-11-12. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Maintenance will conduct weekly environmental rounds with the administrator to check for any further leaks in rest rooms. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** Maintenance will conduct weekly environmental rounds with the administrator to check for further leaks in rest rooms. All findings will be will be fixed immediately.	08/04/12

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F 253	Continued From page 3 turned on. This time the administrator observed the problem himself and reassured the evaluator that the leak would be fixed properly next time. During a final observation on July 12, 2012, at 10:00 a.m. in the morning, the sink was observed with no water leaking underneath when the valve was turned on.	F 253	**What monitoring process and positions of persons responsible fi monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** QA Committee will review findings of environmental rounds at month meeting, any further plans of correction will be implemented immediately.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the fingernails of one of 15 sampled resident's were not long, rough, and discolored. Findings: a. During observations on July 10, 2012, at 7:55 a.m. and 10:25 a.m., Resident 7 was observed in bed with his eyes closed. The resident had a tracheostomy tube (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube) connected to a ventilator (a device that facilitates breathing in cases of respiratory failure). The resident's hands were contracted and his fingernails were observed long, rough, and discolored.	F 312	**What corrective action has been accomplished for the identified resident?** Upon discovery on 7-11-12 resident 7's nails were and cleaned and trimmed down to prevent skin tears. **How will other residents having th potential to be affected to be identified, and what corrective action will be taken.** All Licensed staff was in-serviced b the DON prior to or before 7-13-12 on the importance of nail care of the residents. CNAs were in-serviced by the DON on the importance of checking residents hand and feet to see if their nails need to be trimmed.	08/04/12

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F 312	Continued From page 4 A review of the resident's Record of Admission indicated the resident was admitted to the facility on August 1, 2008, with diagnoses that included respiratory failure, dysphagia, quadriplegia (paralysis of all four limbs), and pneumonia (infection of the lung). The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated February 27, 2012, indicated the resident had a short and long-term memory problem, was severely impaired in his cognitive skills for daily decision-making, rarely/never understood others and rarely/never made himself understood, and required total assistance with all activities of daily living (ADLs). According to the MDS, the resident had impairment on both sides of his upper (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). A review of a care plan dated April 24, 2012, indicated that the resident had a self care deficit due to physical disabilities, cognitive impairment, contractures in both upper and lower extremities, and total dependence on the staff for ADLs. The care plan goal indicated that the resident would be free from body odor and be clean and dressed appropriately daily for 90 days. The listed nursing interventions included to provide skin care daily and nail care as needed. During an an observation on July 11, 2012, at 9 a.m., the resident was observed in bed with his eyes closed and dependent on a ventilator for breathing. The resident's fingernails were long, rough, and discolored. During an interview with the subacute clinical care	F 312	**What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** Nail trimming will be done every week and as needed and recorded on ADL care tracker. A weekly post shower inspection form will be used and completed by the licensed nurse to confirm that the arm band, shower, nail care, hair removal, and skin have been addressed as appropriate. The DON and DSD will monitor for compliance on a weekly basis **What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** DON will monitor for completion weekly. All findings will be brought to QA Committee for review monthly.	

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F 312	Continued From page 6 coordinator on July 11, 2012, at 10:10 a.m., after observing the resident's fingernails with the surveyor, she acknowledged that the resident's fingernails were long and discolored. The subacute clinical care coordinator stated that since the resident had bilateral hand contractures, having long fingernails could potentially result in injury or skin breakdown. According to the subacute clinical care coordinator, the resident's fingernails should have been trimmed at least once a week and as needed. On July 12, 2012, at 8:05 a.m., during an interview with the director of nursing (DON), she stated that the charge nurses are responsible for trimming nondiabetic residents' fingernails every Friday and as needed (PRN) in the subacute unit and every Sunday and PRN on Station 1 and 2. The facility's policy and procedure titled "Care of Fingernails/Toenails" dated April 2007, indicated that the purpose of the procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy and procedure indicated that nail care includes daily cleaning and regular trimming. According to the policy, trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.	F 312		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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F 315	Continued From page 6 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and services for two of 15 sampled residents (2, 6) who had indwelling catheters. Resident 2 had an indwelling catheter with moderate urine smell. Additionally, the indwelling catheter was not secured to the thigh or to the bed. Resident 6 was observed with cloudy drainage and urine sediments indicating urinary tract infection (UTI). These had the potential to result in the resident's inability to attain or maintain the highest physical well being. Findings: a. During an initial tour observation on July 10, 2012, at 7:50 a.m., in Resident 2's room and on July 11, 2012, at 8:35 a.m., the resident was non-verbal and was observed lying in bed on a low air loss (LAL) mattress with oxygen infusing at 2 liters per minute (LPM) via a nasal cannula. Additonally, there was a urine smell emenating from the bed of the resident. The resident was non-verbal during these times. During a bed bath observation on July 11, 2012, at 9:05 a.m., the resident's left arm was flexed on top of her left chest, and an indwelling catheter tubing was observed under her left thigh and the	F 315	**What corrective action has been accomplished for the identified resident?** On 7-11-12 resident # 2's Foley catheter drainage bag was secured with a leg strap. On 7-12-12 for resident #2 and #6 monitoring of urine, color, sedimentation and odor was implemented on treatment record sheet to be completed by the treatment nurse on a daily basis. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Licensed nurses were in-serviced by the DON regarding proper securement of indwelling catheters with leg straps and assessment of urine, color, sedimentation and odor on 7/11/2012. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** Leg straps will be placed on all residents with indwelling catheters for securement. Monitoring of urine, color, sedimentation will be done daily on all residents with indwelling catheters on the treatment record by the treatment nurse.	08/04/12

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F 315	Continued From page 7 catheter tubing was not secured to the bed or to the resident's left thigh. There was a moderate urine smell from the resident's buttock's area. During an interview with the treatment nurse (LVN 1) on July 11, 2012, at 9:15 a.m., she stated that the moderate urine smell could be coming from the LAL mattress that had not been replaced after the placement of the indwelling catheter on July 10, 2012. The treatment nurse also stated that she failed to secure the indwelling catheter tubing to the resident's thigh to prevent the tubing from exerting pressure to the urethra (an opening for the urine to flow from the bladder). During a wound treatment observation on July 12, 2012, at 11:10 a.m., LVN 2 stated that she would inform the hospice agency about the urine smell originating from the indwelling catheter. On the same date, at 1:25 p.m., during an interview, LVN 2 stated that she had irrigated the indwelling catheter with normal saline solution and observed a leak from the urethral opening and obtained an order to replace the indwelling catheter to resolve the condition. The clinical records for Resident 2 were reviewed on July 11, 2012, at 2:30 p.m. The admission sheet indicated the resident was admitted to the facility on October 30, 2008, with diagnoses that included Alzheimer's disease, dysphagia ((inability to swallow or difficulty in swallowing), and unstageable pressure ulcer. A review of the latest quarterly Minimum Data Set (MDS-a standardized resident assessment tool) dated April 18, 2012, indicated the resident had short and long term memory problems, was	F 315	**What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** Weekly monitoring will be done by the treatment nurse and DON for all residents who have indwelling catheters.	

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F 315	Continued From page 8 severely impaired in cognitive (mental) for daily decision-making (never/rarely made decisions). The same MDS, section H0300 indicated the resident was always incontinent (no episodes of continent voiding). b. A review the admission record of Resident 6 indicated the resident was admitted to the facility on August 1, 2008, with diagnoses that included respiratory failure, attention to tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube), dysphagia (difficulty swallowing), and mental retardation. A review of a physician's order dated November 13, 2008, indicated to monitor the resident's urine output for increased sediments and cloudy urine every shift. The order further indicated that if the resident's temperature is elevated, to run a urinalysis (test that evaluates a sample of urine to detect infection) with culture and sensitivity (test to find and identify the bacteria that may be causing an infection) and notify the physician; if there is no fever, to flush the catheter with 60 cc of normal saline and change the catheter and drainage bag in 12 hours if sediments persist. According to a care plan dated July 19, 2011, the resident is at risk of a urinary tract infection(UTI) due to a history of UTI and use of an indwelling suprapubic catheter (a urinary catheter inserted into the bladder through the abdominal wall) for urinary strictures and is at risk for sediments in the urine. The care plan goal indicated the resident's risks for UTI would be minimized for 90 days. The listed nursing interventions included to monitor the resident for signs and symptoms of UTI such as confusion, dark concentrated urine,	F 315		

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F 315	Continued From page 9 cloudy urine, low urine output, foul urine odor, fever, etc. and report, and assess the resident for increase need in hydration when the resident has chronic signs of bacteriuria such as urine sediments or cloudy urine output. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated April 16, 2012, indicated the resident had a short and long-term memory problem, was severely impaired in his cognitive skills for daily decision-making, sometimes understood others and sometimes made himself understood, and required total assistance with all activities of daily living (ADLs). The MDS indicated the resident had an indwelling catheter in place. A review of another physician's order dated May 27, 2012, indicated to flush the resident's suprapubic catheter with 100 cc of normal saline, let it drain out, then flush with 60 cc of acetic acid 0.25%, clamp for 15 minutes, and them unclamp three times a day for chronic UTI and sediments. During the initial tour observation with the subacute clinical care coordinator on July 10, 2012, at 7:55 a.m., and at 9:15 a.m., the resident was observed in bed awake, but nonverbal with a tracheostomy tube in place. The resident had an indwelling suprapubic urinary catheter draining cloudy, yellow urine with thick sediments in the urinary catheter tubing. During multiple observations on July 11, 2012, at 7:50 a.m., 9 a.m., 10:20 a.m., and 3 p.m., the resident was observed in bed. The resident's indwelling suprapubic urinary catheter was observed draining cloudy, yellow urine with	F 315		

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F 315	Continued From page 10 increased and thicker sediments in the urinary catheter tubing. On July 11, 2012, at 3 p.m., during an interview, the surveyor and the treatment nurse went inside the resident's room to check the resident's indwelling urinary catheter. The treatment nurse acknowledged the presence of cloudy urine and the increased sediments in the urinary catheter tubing. According to the treatment nurse, she did not notify the physician because this is a chronic problem for the resident and she just flushed the resident's catheter as ordered. However, during further interview with the treatment nurse on July 11, 2012, at 3:05 p.m., she reviewed the clinical record and was unable to find documented evidence that the resident was continuously assessed and monitored for increased sediments and cloudiness in the urine every shift. A review of the treatment record for July 2012 with the treatment nurse revealed a documentation of "0" under results for monitoring of urine for increased sediments and cloudiness from July 1, 2012 through July 11, 2012 on both shifts. When the treatment nurse was asked what "0" means, she said its means "none" or no sediments. The facility's policy and procedure titled "Catheter Care, Urinary" dated December 2004, indicated that the purpose of the procedure is to prevent infection of the resident's urinary tract. The policy and procedure indicated that the resident must be observed for signs and symptoms of urinary tract infection and findings must be reported to the supervisor immediately. According to the policy, the resident's urine must be check for unusual	F 315		

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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
	055247	A. BUILDING _____ B. WING _____	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

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F 315	Continued From page 11 appearance (i.e., color, blood, etc.).	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for two of 15 sampled residents (6 and 7). The hand rolls were not applied to the hands of Resident 6 and 7 as ordered by the physician to prevent contractures. This had a potential to lead to further decline in range of motion of the residents' hands. Findings: a. A review of the Record of Admission of Resident 6 indicated the resident was admitted to the facility on August 1, 2008, with diagnoses that included respiratory failure, attention to tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube), dysphagia (difficulty swallowing), and mental retardation.	F 318	**What corrective action has been accomplished for the identified resident?** On 7-12-12 the RNAs were in-serviced by DON on the importance of following Restorative Nursing Orders. Resident 6 and 7 had hand rolls placed on them. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Director of Staff Development (DSD) will make daily rounds to ensure that hand rolls are in place. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** Director of Staff Development (DSD) will make daily rounds to ensure that hand rolls are in place. **What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** DSD will bring findings to QA Committee for review monthly.	7/13/12

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

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OMB NO. 0938-0391

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F 318	Continued From page 12 There was a physician's order dated January 24, 2012, indicating to apply a left hand roll daily as tolerated to prevent a contracture. The order further indicated that the hand roll may be removed during patient care. A review of the Rehabilitation: Functional Range of Motion (ROM) and Voluntary Movement Screen dated April 16, 2012, indicated the resident had functional ROM limitations and full loss of voluntary movement to both of his hands. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated April 18, 2012, indicated the resident had short and long-term memory problems, was severely impaired in his cognitive skills for daily decision-making, sometimes understood others and sometimes made himself understood, and required total assistance with all activities of daily living (ADLs). According to the MDS, the resident had ROM impairment on both sides of his upper (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot). A review of a revised care plan dated April 24, 2012, indicated the resident had a self care deficit due to physical disabilities, cognitive impairment, contractures in bilateral upper and lower extremities, and total dependence on the staff for ADLs. The care plan goal indicated the resident would be free from body odor and clean and dressed appropriately daily for 90 days. The listed nursing interventions included to monitor the resident's functional ability daily and report change, for the restorative nursing assistant (RNA) to perform passive range of motion exercises to the resident's bilateral upper and	F 318		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 318	Continued From page 13 lower extremities daily, and to apply a left hand roll daily as tolerated to prevent contractures and the hand roll may be removed during patient care. During multiple observations on July 10, 2012, at 7:55 a.m. and 9:15 a.m., and July 11, 2012, at 7:50 a.m., 9 a.m., 10:20 a.m., and 3 p.m., the resident was observed in bed awake and nonverbal with a tracheostomy tube. The resident's bilateral hands were observed with contractures, but there was no hand roll observed on the resident's left hand. On July 11, 2012, at 3:01 p.m., during an interview with the RNA, he stated that he applied the hand roll on the resident that morning. However, when the RNA and the surveyor went inside the resident's room, there was no hand roll observed in place. The RNA looked through the resident's closet and drawers, but could not find the hand roll. During the interview with the director of nursing (DON) on July 12, 2012, at 8:05 a.m., she stated that the RNA should have applied the hand roll as ordered by the physician. The DON further stated that it is also the certified nursing assistants and licensed nurses' responsibility to check and ensure that the hand rolls are in place as ordered. b. A review of the Record of Admission of Resident 7 indicated the resident was admitted to the facility on August 1, 2008, with diagnoses that included respiratory failure, dysphagia, quadriplegia (paralysis of all four limbs), and pneumonia (infection of the lung).	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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

PRINTED: 07/26/2012
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
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F 323	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the water temperature in the hand sink in the bedroom of resident 6 and 7 was running at a safe temperature to minimize the chance of accidental scalding. Findings: During an environmental tour of the facility on July 10, 2012, at 4:10 p.m., the evaluator tested the temperature of the hot water in the hand sink of the bedroom of residents 6 and 7, using a probe thermometer. With the cold water valve turned off and the hot water valve turned fully on, the evaluator observed the probe thermometer register a temperature of 125 degrees Fahrenheit. A review of the medical records of resident 6 and 7, indicated that they are both totally dependent, confused and not ambulatory. During an interview with the administrator, he stated he would make sure the temperature was	F 323	**What corrective action has been accomplished for the identified resident?** On 7-11-12 the water temperature for the hand washing sink was adjusted to be less than 120 degrees. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Maintenance will conduct weekly environmental rounds as well as check water temperatures to ensure they are with in safe range. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** Maintenance will conduct weekly environmental rounds, as well as check water temperatures to ensure they are with in safe range. All issues will be corrected immediately.	08/04/12

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

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OMB NO. 0938-0391

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F 323	Continued From page 15 lowered immediately. The following day on July 11, 2012, at 2:00 p.m., the temperature was checked again and registered a temperature of 106 degrees Fahrenheit.	F 323	**What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** All findings will be brought to QA Committee monthly.	
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 failed to ensure that it was free of a medication error rate of five percent or greater. During the medication pass observation, three medication errors were observed out of 47 opportunities for errors, to yield a facility medication error rate of 6.3 percent. Findings: a. During a medication pass observation on July 10, 2012, at 9:30 a.m., licensed vocational nurse (LVN) 1 was observed as she prepared the morning medications of a randomly selected resident (RSR 16). LVN 1 informed the surveyor that she would not be able to administer Chlorhexidine liquid (antibacterial oral rinse) scheduled to be given at 9 a.m. because the medication is currently unavailable. During further interview with LVN 1 on July 10, 2012, at 9:35 a.m., she stated that the resident's	F 332	F332 **What corrective action has been accomplished for the identified resident?** On 7-12-12 Licensed staff were in-serviced by the DON on proper medication administration. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** DNS will conduct monthly Med Pass rounds will all licensed staff to ensure that medication administration is being completed properly.	08/04/12

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

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F 332	Continued From page 16 medication was used up as of yesterday. LVN 1 further stated that she notified the facility pharmacy for replacement two days ago, but the medication has not arrived. A review of a physician's order dated June 6, 2012, indicated to administer Chlorhexidine 0.12% 15 milliliters (ml) by mouth, swish and spit, every 12 hours for oral care. During an interview with the director of nursing (DON) on July 12, 2012, at 8:05 a.m., she stated that licensed nurses should regularly check the quantity of medication available to be given to the resident and notify the pharmacy at least two to three days before a medication runs out. The facility's policy and procedure titled "Medication Ordering & Receipt" dated January 2009 indicated that all medications orders will be placed with the providing pharmacy as soon as possible by either telephone or facsimile. Another facility's policy and procedure titled "Medications Unavailable for Administration" dated January 2009 indicated that medications not available for immediate administration to a resident at the time ordered will be followed up on a timely basis to assure that the medication is given as ordered. b. During a subsequent medication pass observation on July 10, 2012, at 10:25 a.m., LVN 1 was observed as she prepared and administered the morning medications of Resident 7. LVN 1 poured 15 ml of Potassium Chloride (supplement) into a medication cup without diluting the medication with water or juice prior to administering it to the resident. The bottle label indicated "must be diluted." According to	F 332	**What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** Licensed staff will be monitored closely by DNS to ensure medication administration is error free. DNS will utilize contracted pharmacy to conduct random medication administration rounds with the licensed staff. **What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** All findings will be reported to CQI committee monthly x 3 months. Necessary actions will be taken.	

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

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F 332	Continued From page 17 the manufacturer's instructions, potassium chloride oral liquid solution must be diluted with water or other liquid to minimize gastrointestinal irritation. During an interview with LVN 1 on July 10, 2012, at 3:35 p.m., she stated that she should have diluted the medication as indicated on the label prior to administering it to the resident. c. During another medication pass observation on July 11, 2012, at 8:12 a.m., LVN 2 was observed as she prepared and administered the morning medications of Resident 12 via gastrostomy tube (GT - a tube inserted through the abdomen that delivers nutrition and medication directly to the stomach). LVN 2 was observed flushing the resident's GT with one cup (approximately 240 ml) of cranberry juice after she administered all of the resident's medications. A review of a physician's order dated January 2, 2012, indicated to flush the resident's feeding tube with a minimum of 50 ml of water after medication administration. During an interview with LVN 2 on July 12, 2012, at 8 a.m., she stated that she flushed the resident's GT with cranberry juice after medication administration because that is the facility's policy. The facility's policy and procedure titled "Medication Administered via an Enteral Feeding Tube" dated January 2009, indicated to flush the feeding tube with 30 to 60 ml of water after all medications have been administered. The three errors out of 47 opportunities for errors yielded a facility medication error rate of 6.3 percent.	F 332		
F 371	483.35(i) FOOD PROCURE,	F 371		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371 SS=E	Continued From page 18 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that food was stored and prepared under sanitary conditions. Findings: During the initial kitchen tour on July 10, 2012, 7:30 a.m. to 8:15 a.m., the following was observed: 1. The temperature reading of the domestic Hot Point refrigerator was measured at 49 degrees Fahrenheit. The dietary supervisor discarded food items from this refrigerator including one gallon of milk, three slices of white cheese, four bags of biscuits, one bag of butter, one cream pie, one jar of mayonnaise, and one four ounce glass of low fat milk. 2. A bucket of sanitized water was tested by the kitchen staff with quaternary ammonia that read zero on the litmus test paper strip. Upon interview the dietary staff person admitted there was no	F 371	**What corrective action has been accomplished for the identified resident?** On 7-10-12: 1. All food items were discarded from the Domestic Hot Point refrigerator and said refrigerator was removed from the kitchen. 2. Sanitizing solution was added to the bucket to ensure it was at proper levels. 3. Repairman was asked to wear a hair net. 4. Sink was repaired. 5. Dishwasher was repaired. 6. Light bulb was replaced. 7. Pots and pans were moved and stored in proper place. 8. Water damage was inspected and celling was repaired. **How will other residents having th potential to be affected to be identified, and what corrective action will be taken.** DSS will monitor weekly to ensure all items are properly stored. **What immediate measures and /o systemic changes will be put into place to prevent reoccurrence?** DSS will conduct weekly inspection of the dietary department. Administrator will received reports regarding findings.	08/04/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 19 measurable sanitizer in the water bucket. The sanitizing solution was to be used to clean the food service area after food distribution and service. 3. The evaluator observed a service repairman from a food service company come into the kitchen and walk past the food preparation area without wearing a hair net and then proceeded to start repairing a beverage machine in the kitchen. 4. The evaluator observed a leak under the two-compartment sink and a white plastic bucket underneath the sink that was used to collect the leaking water. 5. The evaluator observed the rinse max delivery line by the dishwasher machine was leaking. During an interview with the kitchen staff they stated they were aware of the problem. 6. The evaluator observed a burnt out light bulb inside the reach-in freezer. 7. Several pot and pans were observed stored on top of the domestic Hotpoint refrigerator/freezer. 8. The ceiling of the chemical cleaning supplies storage room was observed to have sustained water damage	F 371	**What monitoring process and positions of persons responsible fi monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** DSS will submit findings to CQI committee monthly x 3 months. Subsequent POCs will be implemented as necessary.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425		

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

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F 425	Continued From page 20 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the emergency kit (e-kit) was resealed after use and replaced within 72 hours of use, in accordance with the facility's policy and procedure. This had the potential to result in an untimely administration of medication if medication is needed and not readily available. Findings: During an inspection of the medication room in the subacute unit with the assistant director of nursing (ADON) and registered nurse (RN) supervisor on July 10, 2012, at 8:57 a.m., an injectable e-kit was observed unsealed inside the medication refrigerator. Upon further observation, the injectable e-kit was observed missing one vial of Ativan (antianxiety) 2 milligrams per ml	F 425	**What corrective action has been accomplished for the identified resident?** On 7-10-12 the Pharmacy was notified and a replacement E-Kit was delivered. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Licensed staff were in-serviced on 7/10/12 on the importance of notifying the pharmacy promptly after a drug has been removed from the E-Kit. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** The E-Kit will be checked daily by Charge nurse/ RN Supervisor and will be re-ordered when indicated. **What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** DON will bring findings to QA Committee meeting monthly for 3 months.	08/04/12

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

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F 425	Continued From page 21 (mg/ml). During a review of the e-kit log with the ADON and the RN supervisor on July 10, 2012, at 8:59 a.m., there was an e-kit log entry indicating that the vial of Ativan was last pulled out from the e-kit on April 28, 2012 (more than two months ago). On July 10, 2012, at 8:59 a.m., during an interview, the RN supervisor stated that when a medication is taken out from the e-kit, the pharmacy should be notified right away for replacement and the e-kit should be resealed after opening with a red tamper-resistant lock that came with the kit. The facility's policy and procedure titled "Emergency Drug Supply" dated January 2009, indicated that the pharmacy will be notified anytime the seal of the emergency drug supply is broken. The nurse will notify the pharmacy of the use of the emergency drug supply by facsimile or telephone and record the order on the pharmacy order sheet, including the use of the drug supply. The nurse will reseal the emergency drug supply with the seal inside the drug supply. The pharmacy will replace the emergency drug supply within 72 hours. At shift change the staff will observe and record the status of all emergency drug supplies.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconcillation; and determines that drug	F 431		

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

PRINTED: 07/25/2012
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
	055247	A. BUILDING _____ B. WING _____	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY OAKS CARE CENTER	215 W PEARL ST POMONA, CA 91768

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F 431	Continued From page 22 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to discard expired vial (small bottle) containing Purified Protein Derivative (PPD). This resulted in a potential to cause inaccuracy of the Tuberculosis skin test screening.	F 431	**What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?** DON will conduct monthly med cart inspections to ensure all expired meds are disposed of properly. Supervisors will conduct weekly audit of CDI to ensure all signatures are present during weekly rounds. **What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** Findings of DON and Departmental Supervisors will be brought to the CQI Committee monthly x 3 months. Subsequent plans of correction will **What corrective action has been accomplished for the identified resident?** On 7-10-12 an in-service was given to all licensed staff by the DON regarding med cart policy and procedure and proper CDI procedure.	08/04/12

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F 431	Continued From page 23 Additionally, the facility failed to ensure that all Controlled Drug Inventory (CDI) sheets, in 2 of 3 nursing stations (Station 1, Station 2) and Subacute unit, were signed by all shifts. The licensed nurses failed to sign the CDI sheets in nursing stations 1 and 2, for multiple dates, on various shifts, for the months of March, April, May, June and July 2012. Findings: a. During a routine medication room inspection and observation at the nursing station 1, on July 10, 2012, at 10:55 a.m., the Evaluator, together with Licensed Vocational Nurse (LVN 1), observed a, a multiple dose vial of PPD marked with an open date of June 9, 2012. PPD is a solution used to administer a skin test for screening of tuberculosis to newly admitted residents. On July 10, 2012, at 11:05 a.m., during an interview, LVN 1 stated the medication should have been discarded on July 9, 2012, which was one day past the manufacturer's recommendation to discard the medication thirty days after opening. LVN 1 further stated it should have been identified by the licensed nurse when the supply of medications were checked at the beginning of the 7 a.m. to 3 p.m. shift. b. On July 10, 2012, between 11:15 a.m. and 11:35 a.m., the Evaluator reviewed the CDI sheets with LVN 1, who stated two licensed nurses would count the controlled drugs at the change of shift, where the incoming nurse, 7 a.m. to 3 p.m. shift, would count the number of	F 431	**How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** DON will conduct monthly med cart inspections to ensure all expired medications are disposed per policy and procedure. Supervisors will conduct weekly audit of CDI to ensure all signatures are present during weekly rounds.	

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F 431	Continued From page 24	F 431		

narcotics in the bubble pack, and the outgoing nurse, 11 p.m. to 7 a.m. shift, would call out the balance on the individual narcotic sheet. Both of them would sign the CDI Sheet after the supply was counted and the count of narcotics were correct for each resident receiving narcotics.

The CDI sheets on Station 1 were reviewed with LVN 1, which revealed the licensed nurses did not sign the records on the following dates, on various shifts: March 2, 7, 13, 14, 15, 18, 19, 20, 23 and 27, 2012; April 3, 19, 20, and 28, 2012; May 2, 4, 7, 9, 13, 21, 22, 27 and 29, 2012; June 4, 5, 7, 9, 13, 21, 22, 27, and 29, 2012, and July 1, 3, 4, 5 and 9, 2012.

Further review of the CDI Sheets on Station 2 with LVN 1, revealed the licensed nurses did not sign the records on the following dates, on various shifts: May 7, 17, 19, and 31, 2012; June 6, 7, 9, 12, 16, 17 and 19, 2012; and July 6 and 9, 2012.

During an interview with the director of nursing (DON) and LVN 1, on July 10, 2012, at 11:36 a.m., both of them stated all of the licensed nurses should have signed the CDI sheets at the end of every shift when completing the narcotic count.

The facility's policy and procedure titled "Every Shift Controlled Drug Recolciliation," dated January 2009 indicated the controlled drug quantities will be verified and reconciled at the change of each nursing shift by the "on-coming" and "off-going" nurses and reconcile controlled drugs subject to regulations and/or facility policies for individual counts. Each nurse will sign on a

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F 431	Continued From page 25 "Controlled Drug Inventory" form. The same policy indicated all controlled drugs, as defined in the "Routine Accountability" will be counted and reconciled before the "off-going" nurse transfers the keys to the "on-coming nurse. Additionally, a review of the manufacturer's recommendation for the PPD solution indicated once entered (opened), the vial should be discarded after 30 days due to possible oxidation and degradation (the reduction of a chemical compound to a less complex compound), which may affect the medications potency (strength). c. During an inspection of the medication room in the subacute unit with the assistant director of nursing (ADON) and registered nurse (RN) supervisor on July 10, 2012, at 8:57 a.m., two open vials of Tuberculin Purified Protein Derivative (PPD- aid in the detection of infection with Mycobacterium tuberculosis) were observed without open dates. During an interview with the RN supervisor on July 10, 2012, at 8:58 a.m., she inspected the two vials of PPD and could not tell when the vials were first opened. She stated that the PPD vial should have been labeled with an open date. The facility's policy and procedure titled "Date Open Procedures" dated January 2009, indicated that certain products have limited expiration dates after the product has been mixed or opened for the first time. The policy indicated that on containers that do not have a space to record the opening date on the manufacturers' label the pharmacy will affix a blank "Date Opened" sticker to the container. It will be the responsibility of the	F 431		

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F 431	Continued From page 26 nursing staff to enter the opening date on all manufacturers' labels or blank pharmacy labels.	F 431		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide bedrooms which must measure at least 80 square feet (sq. ft.) per residents in multiple resident bedrooms, for 11 of 32 bedrooms. Rooms # 115, 116, 117, 118, 119, 120, and 129, 130, 131, 132, 133, did not meet the minimum square footage requirement for multi-bedrooms. Findings: On July 10, 2012, at 8:00 a.m., the administrator submitted a room wavier request for 11 resident rooms, which included the square footage for the 11 resident rooms. A review of the wavier revealed the following: Room # / # of Beds / Sq. Ft. 115 / 3 / 227 116 / 3 / 227 117 / 3 / 227 118 / 3 / 218 119 / 3 / 227 120 / 3 / 227 129 / 3 / 209 130 / 3 / 209	F 458	On 7-10-12 a letter was submitted requesting a room waiver for the noted 11 rooms 115, 116, 117, 118, 119, 120, 129, 113. 131, 132, and 133 which did not provide the minimum square footage required for a 3-bedroom which should be 240 sq. ft.	08/04/12

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F 458	Continued From page 27 131 3 209 132 3 228 133 3 228 The minimum square footage requirement for a three-bedroom should be at least 240 sq. ft. On July 10, 2012, at 3:05 p.m., during a general observation, the evaluator noticed that Rooms # 115, 116, 117, 118, 119, 120, 129, 130, 131, 132, and 133, had three beds per room. Rooms # 119, 120, 129, 130, 131, 132,133, which were in the Sub-Acute unit, had ventilators, oxygen tanks and tube-feeding machines. During the course of the survey from July 10 through 13, 2012, the evaluator observed that the residents had wheel chair access and were able to propel themselves in and out of their rooms. The staff had access to provide treatment, pass medication and assist the residents with morning care and activities of daily living. During the course of the survey from July 10 through 13, 2012, interviews were conducted with residents both collectively and individually, and none of the residents complained about the size of their of their rooms.	F 458	**What corrective action has been accomplished for the identified resident?** 1. On 7-10-12 the bed and toilet call lights of resident 8 and the call light for resident 9 at the sub-acute nurse station were repaired to produce an audible alarm. 2. On July 11, 2012 the call light buttons at the 2 shower stalls in the shiower room near the skilled nursing were repaired to enabled the alarm and emergency to be turned on. **How will other residents having the potential to be affected to be identified, and what corrective action will be taken.** Maintenance will conduct weekly environmental rounds as well to ensure call lights are working properly. **What immediate measures and /or systemic changes will be put into place to prevent reoccurrence?**	08/04/12
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463	Maintenance will conduct weekly environmental rounds, to ensure all call lights are functioning properly. All issues will be corrected immediately.	

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F 463	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, the facility maintenance staff failed to ensure that the nurses' station was equipped with a fully functional communication system to receive resident calls from the bedroom and the common shower room. Findings: 1. On July 10, 2012, from 4:00 PM to 4:30 PM, the bed and toilet call lights of resident 8 and the bed call light of resident 9 did not produce an audible alarm at the sub-acute nursing station when tested. 2. On July 11, 2012, at 3:35 p.m., the call light buttons at the two shower stalls in the common shower room near the skilled nursing station did not function. When the evaluator pushed in the buttons they immediately popped back out so that the alarm and emergency light could not be turned on.	F 463	**What monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.** QA Committee will review findings of environmental rounds at monthly meeting, any further plans of correction will be implemented immediately.	