STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED
	055240	A. BUILDING _____ B. WING _____	06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA WATSONVILLE EAST NURSING CENTER	535 AUTO CENTER DRIVE WATSONVILLE, CA 95076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an annual recertification survey conducted from 6/20/11 through 6/24/11. One entity reported incident and one complaint were investigated during the recertification survey. For Entity Reported Incident CA00273619 regarding Quality of Care and Treatment, the Department did not identify a violation of Federal or State regulations. For Complaint CA00277965 regarding Quality of Care and Treatment, Federal deficiencies were written (see F281 and F514). The facility was licensed for 87 beds. The census at the time of the survey was 73. The sample size was 15. Representing the California Department of Public Health: 29260, Health Facilities Evaluator Nurse; 25076, Health Facilities Evaluator Nurse; and 22899, Health Facilities Evaluator Nurse.	F 000	**Country Villa Watsonville East Nursing Center 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 employees, 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 for evaluation and appropriate treatment modalities.	7/29/11
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be	F 156	F156 The facility posted the name, address, and telephone number of the Protection and Advocacy Network (MR and MI) and the	7/29/11

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
JUL 19 2011
L & C DIVISION
SAN JOSE

LA[redacted]ATIVE'S SIGNATURE | TITLE | (X6) DATE

Asst. Administrator 7/18/2011

A[redacted]ficiency which the institution may be excused from correcting providing it is determined that ot[redacted] 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 156	Continued From page 1 made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community	F 156	Medi-cal Fraud Control Unit on the consumer board. A statement indicating a complaint can be file with the Department concerning resident abuse, neglect, and misappropriation of resident property was also posted. The Administrator has audited the consumer board to ensure there is no other missing information on the consumer board. The Administrator will receive inservice education from the Vice President of Operations (VPO) on the required posting for the consumer board. On an ongoing basis, the VPO will conduct a random monthly audit of the consumer board to ensure the Administrator has the required information on the consumer board. The audit will be given to the Administrator for corrective action.	

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F 156	Continued From page 2 spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and	F 156	The Administrator will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 156	Continued From page 3 applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the name, address and telephone number for the Protection and Advocacy Network (MR and MI) and the Medi-Cal Fraud control unit. Also, a statment indicating a complaint can be filed with the Department concerning resident abuse, neglect and misappropriation of resident property in the facility was not posted. Findings: During an observation on 6/22/11 at 8 a.m., the facility lobby had boards located next to the business office which were for Federal postings. There were no names, addresses or telephone numbers posted for the protection and advocacy network or Medi-Cal fraud control unit where the Federal postings were located. There was also no posting indicating a complaint could be filed with the California Department of Public Health concerning resident abuse, neglect and misappropriation of resident property in the facility. During an interview with the administrator on 6/22/11 at 8:45 a.m., he stated he was not able to find the postings of the names, addresses or telephone numbers of the Protection and Advocacy Network or Medi-Cal fraud unit. He also stated there was no posting indicating a complaint could be filed with the Department	F 156		

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F 156	Continued From page 4 concerning resident abuse, neglect or misappropriation of resident property in the facility.	F 156	F164 The medical information/instructions for care have been removed from the wall above Resident 16's bed. The Department Supervisors have audited all other resident rooms to ensure no other medical information/instructions for care are posted in the resident rooms. The Director of Staff Development (DSD) will provide inservice education to the staff, including the Speech Therapist, on not posting medical information/instructions for care in the resident's room On an ongoing basis, the Department Supervisors will conduct a random weekly audit of their assigned rooms to ensure that no medical information/instructions for care is posted in the resident's	7/29/11
F 164 SS=D	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. 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 observation and interview, the facility	F 164		

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F 164	Continued From page 5 failed to provide privacy for one non-sampled resident (16) when medical condition and/or instructions for care were posted on the wall above Resident 16's bed. Findings: During the initial tour with licensed nurse A (LN A) on 6/20/11 at 8:20 a.m. the following were observed: A sign with the resident's name and date 4/1/10 was posted above his bed with instructions visible to any visitor that entered the room. Resident 16 was in a three bed room. Diet level- Puree Liquid Level- regular Positioning: Fully upright on chair/bed at 90 degrees Assist- MAX Technique- alternate liquids between each bite of puree to clear pocketed food from mouth (puree-liq-puree). Another sign posted next to the above sign with dining instructions listed: Please CNAs- Brush [Resident 16's] teeth everyday. Use toothpaste (he does not have any). During an interview with LN A on 6/20/11 at 8:20 a.m., she stated the instructions for dining looked like they were from the speech therapist and the other sign looked like it was from a family member. She made no effort to remove or cover the signs with resident information and care instructions on the wall above the resident's bed. During an observation on 6/22/11 at 9:30 a.m., the same signs were observed hanging on the wall above Resident 16's bed.	F 164	rooms. The result of the audit will be given to the Administrator for corrective action. The Administrator will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure five of nine confidentially interviewed residents did not feel rushed out of the dining room when meals were served late. It is important for residents to feel relaxed while eating since they live at the facility and the facility is their home. Findings: During an observation on 6/20/11 at 1:00 p.m. residents were observed eating in the independent dining room. During confidential interviews on 6/21/11 five independent residents stated meals were served up to one hour late. They felt rushed out of the dining room because housekeeping had to clean the dining room prior to the start of activities. They were still eating after 1:00 p.m. The residents stated they expected their meals at 12:00 p.m. and did not like feeling rushed while eating. During record review on 6/21/11 the posted meal times outside the kitchen indicated breakfast was served from 7 a.m. to 8 a.m.; lunch was served from 12 noon to 1 p.m., and dinner was served from 5 p.m. to 6 p.m.	F 241	F241 The Dietary Services Supervisor (DSS) conducted an audit of meal delivery out of the kitchen at all three meals and determined to change the order of the carts leaving the kitchen. The cart with the trays for the independent residents in the dining room will be delivered first to allow them more time with their meals. The DSD, Environmental Service Supervisor, and the Activity Director conducted an audit of the dining experience at all three meals to identify reasons why the residents feel rushed to complete their meals. The DSS and DSD will provide inservice education to the dietary staff on the ensuring proper delivery time of trays including the new order of the carts leaving the kitchen. The DSD will provide inservice education to the CNAs on ensuring that the residents are allowed sufficient time to complete their meals.	7/29/11

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F 241	Continued From page 7 During an interview and record review on 6/23/11 at 12:26 p.m., the dietary services supervisor (DSS) stated the meal times posted outside the kitchen indicated the range of time meals were served. She stated it was rare for the meals to be served one hour late. She stated different groups of residents received their meals at different times within the posted range. She also stated the cart containing lunch and dinner trays for independent residents was placed outside the kitchen at 12:25 p.m. and staff would distribute the trays. During an interview on 6/24/11 at 8:16 a.m., housekeeping staff stated he had to start cleaning the independent residents' dinning room at 1:00 p.m. He also stated activity staff wanted the room empty by 1:30 p.m. so activities could start by 1:45 p.m. During an interview with the activity director (AD) 6/24/11 at 9 a.m., she stated she needed the independent residents' dining room cleaned by 1:30 p.m. so she could have the room ready for resident activities by 1:45 p.m.	F 241	The Environmental Services Supervisor will provide inservice education to the janitorial staff on not rushing the residents to complete their meals in order to start cleaning. The DSD will provide inservice education to the Activity Director and activity staff on allowing the residents to have sufficient time to complete their meal and not rushing the residents to complete their meals so that the dining room can be cleaned to start activities. On an ongoing basis, the DSS will conduct a random weekly audit of meal delivery times to ensure that meals are delivered out of the kitchen on time and in the correct order. The DSD will conduct a random weekly audit of the dining room to ensure that the residents are being allowed sufficient time to complete their meals.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 8 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop or revise comprehensive care plans that addressed the medical and nursing needs for five of 15 sampled residents (2, 3 ,4, 9, and 10). Resident 2's care plans were not revised for the use of Dilantin and Paxil. Resident 3's nutritional care plan and speech therapy care plan were not revised to included cueing for small bites. Resident 4's nutritional care plan did not indicate the resident was on a planned weight loss and a care plan for dialysis was incomplete. Resident 9's care plan for the use of Lasix was not revised and a care plan for the use of a probiotic was not developed. Resident 10's nutritional care plan was not revised to include desired weight loss. Nursing care plans are used to develop a plan to ensure the residents' problems are identified and their needs are met consistently and safely. Findings: 1. Resident 2 was admitted to the facility with diagnoses including elevated blood pressure, and diabetes mellitus II (elevated blood sugar).	F 279	The DSS and DSD will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations. F279 Resident 2's care plan has been revised for the use of Dilantin and the discontinuation of the Paxil. Resident 3's nutritional care plan and speech therapy care plan have been revised to include cueing for small bits. Resident 4's nutritional care plan has been revised to include that the resident is on a planned weight loss program. Resident 4's care plan for dialysis have been completed and is accurate. Resident 9's care plan has been revised for the use of Lasix. Resident 9's care plan of the use of probiotic was updated to reflect the discontinuation of the medication.	7/29/11

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F 279	Continued From page 9 Record review on 6/21/11 at 10:05 a.m. of the care plan for "Risk for Falls/Injury" indicated Resident 2 was "Currently on:" Oscal, Dilantin, and Paxil. During an interview on 6/21/11 at 11:25 a.m. licensed nurse B (LN B) stated the medication Paxil was discontinued but the care plan indicated Resident 2 was currently on Paxil. 2. Record review on 6/21/11 at 9:25 a.m. of physician's order for Resident 2 dated 3/28/11 indicated to decrease "Dilantin to 3 ml po (by mouth) TID (three times a day)" and "Dilantin level in 6 weeks." Record review on 6/21/11 at 9:25 a.m. of Resident 2's short term care plan for Dilantin "Short Term Problems" "Concern & Problems" indicated "Critical High Dilantin Level." "Patient Goals" were listed as "level will be within normal range w/i (within) 14 days." The "Approach Plan" indicated, "Hold Dilantin per MD (medical doctor) order" and "labs as ordered by MD." During an interview on 6/21/11 at 9:10 a.m. LN A stated the Dilantin was not drawn in 6 weeks as ordered by the physician. She further stated this lab was not "captured." "Labs as ordered by MD" listed on the Dilantin care plan were not drawn. During an interview on 6/21/11 at 11:25 a.m. licensed nurse A (LN A) stated the doctor did not order to hold Resident 2's Dilantin as the care plan indicated, but ordered to decrease the dosage. Record review of care plan for a "Critical High	F 279	Resident 10's nutritional care plan has been updated to include the desired weight loss. The IDT has audited all other care plans of residents using Dilantin, Paxil, probiotic, and Lasix to ensure the use or discontinuation of these medications are accurately reflected on the care plan. The IDT has audited all other residents on dialysis to ensure that the dialysis care plans are complete and accurate. The IDT, including the Registered Dietitian, has audited all other nutrition and speech therapy care plans for completeness and accuracy. The IDT made corrections to the care plans at the time of the audit. The DSD will provide inservice education to the licensed nursing staff, the Speech Therapist, and the Registered Dietitian on development and revision of care plans with an emphasis on ensuring they are complete, comprehensive, and up-to-date.	

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F 279	Continued From page 10 Dilantin Level" dated 3/28/11 listed "Patient Goals" indicated "level will be within normal range w/i 14 days," although the doctor's order indicated Dilantin level would be checked in six weeks. 3. Resident 4 was admitted to the facility with diagnoses including diabetes mellitus and dialysis. According to the 5/24/11 MDS the resident had no cognitive impairment. During record review on 6/20/11 the weight log indicated the resident's weight was 251.4 pounds on 9/1/10 and 233.6 on 11/1/10. On 12/1/10 the resident was 227.2 pounds. The 12/10/10 physician's order indicated the resident was on a small portion diet. The 11/23/10 "Weight Variance Committee Assessment" form indicated the resident was on a planned weight loss regime and his diet was appropriate due to the resident's diabetes and dialysis. The document indicated the resident was making progress on the weight loss plan. There was no evidence on any of the care plans including the 11/6/08 "Nutritional Risk" care plan indicating the resident was on a planned weight loss program. 4. During record review on 6/20/11 Resident 4's dialysis care plans dated 7/2/10 and 3/14/11 did not indicate what arrangements the facility made for the resident's medication administration on dialysis days and what was the resident's diet. According to the 8/1/97 policy and procedure "Hemodialysis, Care of Resident" the policy indicated the facility was to document information	F 279	On an ongoing basis, the Medical Records Director (MRD) will audit the care plans upon admission, with a change of condition, and when an order is initiated or discontinued to ensure they are reflected on the care plan completely and accurately. The MRD will give the results of the audit to the responsible department supervisor for corrective action. The Director of Nursing (DNS) will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 279	Continued From page 11 regarding arrangements "if any for medications on dialysis days" and "renal diet" (a diet specific to residents who have impaired kidney function) in the patient's care plan. During an interview and record review on 6/23/11 at 12:06 p.m., the director of nurses (DON) stated Resident 4's nutritional care plan did not indicate the resident was on a planned weight loss program and the dialysis care plan did not follow the facility's policy and procedure when there was no indication on the care plan regarding what arrangements the facility made regarding the resident's medications on dialysis days and what the resident's diet was. 5. Resident 3 was admitted to the facility with diagnoses including hypertension. The Minimum Data Set (MDS, an assessment tool) dated 5/12/11 indicated Resident 3 had modified independence in cognitive skills for daily decision making and needed assistance with set up for meals. Resident 3's clinical record was reviewed on 6/20/11. The physician's order dated 6/3/11 indicated a speech evaluation. The speech therapy clarification of treatment plan dated 6/3/11 indicated the resident was to be seen three times a week for two weeks for dysphagia management. Treatment to include diet modification/analysis, fluids by mouth trails and safety precautions. The Speech Therapy Treatment Record dated 6/3/11 indicated nursing reported to speech therapy, resident coughing during meal intake.	F 279		

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	055240	A. BUILDING _____ B. WING _____	06/24/2011

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F 279	Continued From page 12 The Speech Therapy Treatment Record dated 6/6/11 indicated Resident 3 had one episode of coughing, may be secondary to rapid rate of eating. Spoke with resident attempting to decrease pace of eating to minimize risk of choking. Requested certified nurse assistant (CNA) to increase cuing when in dining room and remind resident to eat/drink slowly. During an observation of Resident 3 on 6/20/11 at 12:30 p.m., she was observed eating in the independent dining room. She was observed taking large bites of meat balls and drinking juice. She coughed once during the meal. During interview and record review with speech therapy (ST) on 6/22/11 at 9:20 a.m., she stated the care plan for Dysphagia (developed by speech therapy) and Nutritional care plan did not include instructions to the CNA to increase cuing "to take small bites of food when in the dining room and to remind Resident 3 to eat and drink slowly". She also stated these instructions should have been listed under safety precautions on the care plan because the instructions were an approach to the resident's care. 6. Resident 9 was admitted to the facility with diagnoses including edema (swelling of both ankles) and hyperpotassemia (an abnormally high level of potassium in the blood). The MDS dated 5/31/11 indicated Resident 9 was moderately impaired in cognitive skills for daily decision making. The clinical record was reviewed on 6/22/11. The physician's order dated 1/20/11 indicated	F 279		

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F 279	Continued From page 13 Florastor (probiotic, helps maintain intestinal balance) 250 milligrams one tablet by mouth two times a day. The physician's order dated 5/12/11 indicated Lasix 10 milligrams by mouth every two days for edema. During an interview and record review with licensed nurse C (LN C) on 6/22/11 at 10:55 a.m., he stated the care plan for the use of Lasix was listed under the Potential for Dehydration dated 2010. He stated the care plan was not revised to include the new order for the Lasix and the goals and approach plan were discontinued when the order was changed. He stated there was also no care plan developed for the use of the Florastor ordered by the physician and he did not know what the medication was used for. 7. Resident 10 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD). The MDS dated 4/7/11 indicated Resident 10 was independent in cognitive skills for daily decision making. The clinical record for Resident 10 was reviewed on 6/23/11. The weight record for January 2011 to June 2011 was reviewed. The weight record indicated Resident 10 had a weight loss of 40.6 pounds over five months. The Registered Dietician Progress Notes dated 6/7/11 indicated Resident 10 had an intake of 75/75/75 on a regular diet and was meeting estimated needs. Noted with weight loss of 11.02% in 90 days and 16.70% in 180 days per monthly weights. Resident states good appetite, no food complaints and has been snacking on junk food while trying to lose weight. Resident	F 279		

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F 279	Continued From page 14 making good progress on goal. Weight loss related to decrease in caloric intake from snack foods, weight loss desirable. Recommend refer to interdisciplinary team (IDT) weight variance meeting. The Weight Variance Committee Assessment dated 6/9/11 indicated weight loss desirable and expected. During an interview with Resident 10 on 6/23/11 at 8:45 a.m., he stated he wanted to lose weight and was happy with his weight loss. He also stated "I use to eat a lot of junk food". During an interview and record review with licensed nurse E (LN E) on 6/24/11 at 9:10 a.m., she stated the Nutritional Care Plan for Resident 10 dated 6/7/11, did not include the resident's desire to lose weight. The facility policy and procedure, "Interdisciplinary Plan of Care" dated 2/1/96, indicated resident needs shall be assessed on "an ongoing basis" and "updated whenever the patient's condition changes and new needs are identified or when existing needs are resolved."	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure physician orders were followed	F 281	F281 The facility has obtained a new Dilantin level for Resident 2. The facility has obtained a new CMP and Digoxin level for Residnet 7. Resident 14's physician was notified that the resident did not receive the Diltiazem as order. Resident 14 discharged on 6/14/11. The MRD has audited all lab orders within the last 30 days to ensure that all labs where drawn and results sent to the physician as ordered. The MRD has audited the MAR for the past 30 days to ensure that all other residents receiving Diltiazem had the medication administered as order. The results of the audit were given to the DNS for corrective action.	7/29/11

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F 281	Continued From page 15 for three of 15 sampled residents (2, 7, and 14). For Resident 2, the facility failed to follow a physician's order to draw a Dilantin level in six weeks. For Resident 7, the facility failed to follow a physician's order to draw a comprehensive metabolic panel (CMP) and a Digoxin (a medication for the heart) level every six months. For Resident 14, the facility failed to follow a physician's order to administer Diltiazem (used to treat elevated blood pressure and angina) ER (extended release). Findings: 1. Resident 7 was admitted to the facility with diagnoses including muscle weakness and hypercholesterolemia (elevated cholesterol in the blood). The 3/29/11 Minimum Data Set indicated the resident was not cognitively impaired. During record review on 6/23/11 the 3/26/10 care plan "Potential for Altered Cardiac Function" indicated the resident was on Digoxin and Zocor (a medication used to decrease unwanted cholesterol levels). Interventions on the care plan included "Labs as ordered." The physician's order indicated the facility was to obtain a complete metabolic panel ("CMP lipids") every six months starting 7/19/10 and digoxin level every six months starting 5/3/10. The last CMP and digoxin level found in the clinical record was dated 11/5/10. There was no evidence in the clinical record nursing was aware and notified the physician the laboratory data was not done as ordered. During an interview and record review on 6/23/11 licensed nurse E (LN E) reviewed Resident 7's clinical record and stated CMP's or digoxin levels	F 281	The DSD will provide inservice education to the licensed nursing staff on following physican's order for obtaining labs as ordered and administering medications as ordered by the physician. On an ongoing basis, the MRD will keep a log of all new and standing lab orders to track the lab drawn, receipt of the lab, and notification to the physician to ensure that all labs are completed as ordered. The MRD will complete a random weekly audit of the MAR to ensure that medications are administered as ordered by the physician. The audits will be given to the DNS for corrective action. The DNS will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 281	Continued From page 16 due in 2011 were not done. "According to the 6/10 charge nurse job description licensed nurses "coordinate nursing care...reports results of labs to physician documenting call, response...performs tests, treatments and procedures as ordered by the physician...completes appropriate follow-up to new orders...." 2. Resident 2 was admitted to the facility with diagnoses including high blood pressure. Record review on 6/21/11 at 9:25 a.m. indicated a blood draw was done on 3/28/11 at 7:25 a.m. The laboratory results indicated Phenytoin, Total (Dilantin) level was 30.2, a critically high range. (Reference range is 10.0 - 20.0.) Record review on 6/21/11 at 9:25 a.m. of physician's order dated 3/28/11 indicated "Dilantin level in 6 weeks." During an interview on 6/21/11 at 9:10 a.m. LN A stated the Dilantin level was not drawn in 6 weeks as ordered by the physician. She further stated this lab was not "captured." 3. Resident 14 was admitted to the facility with diagnoses including elevated blood pressure. Record review on 6/28/11 at 3 p.m. of the June 2011 MAR (medication administration record) for Resident 14 indicated Diltiazem ER (extended release) was not given at 9 a.m. on 6/14/11 as ordered. It also indicated licensed nurses' initials and signatures were not listed on the back of the MAR to identify nurses administering medication	F 281		

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F 281	Continued From page 17 to Resident 14. During an interview on 6/24/11 at 10 a.m. LN D stated she did not give the Diltiazem because "we had SR (sustained release) not ER (extended release). She further stated, "I think the pharmacy said ER and SR is equivalent. We had SR in the bottle the pharmacy sent. I didn't give it because we had SR and the order was for ER. I probably should have signed and circle that it wasn't given awaiting pharmacy notification if ER and SR were the same." During an interview on 6/28/11 at 1:50 p.m. the PC (pharmacist consultant) stated based on the pharmacy records Diltiazem 120 ER was sent for Resident 14. During an interview on 6/28/11 the PT (pharmacist technician) stated the medication was sent from a satellite and was processed as Diltiazem ER and sent to the facility. Record review on 6/24/11 at 10:15 a.m. of policy and procedure dated 2/1/96 "Documentation - Licensed Nurses" indicated "The nurse's full name and title must be written at least once on each page of the medication/treatment record. If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the patient not receiving the medication." The facility's April 2008 policy and procedure "Medication Orders" indicated. "Any dose or order that appears inappropriate. . . is verified with the attending physician."	F 281	F282 A care plan for "Potential for Altered Cardiac Function" has been implemented for Resident 7. The facility has obtained a CMP and digoxin level for Resident 7.	7/29/11
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 18 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the comprehensive care plan for one of 15 sampled residents (7) was implemented. For Resident 7, the facility failed to implement the care plan for "Potential for Altered Cardiac Function". Findings: Resident 7 was admitted to the facility with diagnoses including muscle weakness and hypercholesterol (increased cholesterol in the blood). The 3/29/11 Minimum Data Set (MDS, an assessment tool) indicated the resident had no cognitive impairment. During record review on 6/23/11 the 3/26/10 care plan "Potential for Altered Cardiac Function" indicated the resident was on Digoxin and Zocor (a medication used to decrease unwanted cholesterol levels). Interventions on the care plan included "Labs as ordered." The physician's order indicated the facility was to obtain a comprehensive metabolic panel ("CMP lipids") every six months starting 7/19/10 and digoxin level every six months starting 5/3/10. The last CMP and digoxin level found in the clinical record was dated 11/5/10.	F 282	The IDT has audited all other residents with "Potential for Altered Cardiac Function" care plans to ensure that they have been implemented. The IDT made corrections at the time of the audit. The MRD has audited all lab orders within the last 30 days to ensure that all labs where drawn and results sent to the physician as ordered. The DSD will provide inservice education to the licensed nursing staff on the implementation of care plans with an emphasis on the "Potential for Altered Cardiac Function" care plan and obtaining labs as ordered by the physician. On an ongoing basis, the MRD will keep a log of all new and standing lab orders to track the lab drawn, receipt of the lab, and notification to the physician to ensure that all labs are completed as ordered. This will include labs listed on the "Potential for Altered Cardiac Function" care plan.	

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F 282	Continued From page 19 During an interview and record review on 6/23/11 licensed nurse E (LN E) reviewed Resident 7's clinical record and stated CMP's and digoxin levels due in 2011 were not done. According to the 2/1/96 "Interdisciplinary Plan of Care" The responsibilities of the team members include ...implementation of a comprehensive individualized plan of care...."	F 282	The DNS will provide a summary trends analysis of the log findings to the CQI steering committee for further evaluation and/or recommendations.	
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 interview and record review, the facility failed to follow the facility policy and procedure regarding what to do when one of 15 sampled residents (10) refused to allow staff to weigh him. Policies and procedures are implemented to ensure consistent staff performance. Policies and procedures give guidelines as to what staff should do, such as, when a resident refuses his weight to be taken. Findings: Resident 10 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD). The Minimum Data Set (MDS, an assessment tool) dated 4/7/11 indicated Resident 10 was independent in	F 309	F309 The physician has been notified of Resident 10's refusal to be weighed. The MRD has audited all other medical records for residents who refuse to be weighed for physician notification. The results of the audit were given to the DNS for corrective action. The DSD will provide inservice education to the licensed nursing staff on the facility's policy and procedure of notifying the physician when a resident refuses to be weighed. On an ongoing basis, the MRD will audit the weekly and monthly weight records to ensure that the physician is	7/29/11

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F 309	Continued From page 20 cognitive skills for daily decision making. Resident 10's clinical record was reviewed on 6/23/11. The weight records for January 2011 to June 2011 were reviewed. The weight record indicated Resident 10 had refused to be weighed on 4/1/11. There was no documentation on the weight record, nurses notes or dietary notes indicating Resident 10's physician was notified concerning refusal to be weighed on 4/1/11. There was a 19.6 pound weight loss from the weight taken on 3/1/11 and the weight taken on 5/1/11. During an interview and record review with licensed nurse E (LN E) on 6/24/11 at 12:20 p.m., she stated when a resident refuses to be weighed and staff has tried at least three times to weigh him, the physician should be notified. She stated staff should indicate on the clinical record by documentation, the physician was notified and there was no documentation on the clinical record indicating the physician was notified concerning Resident 10's refusal to be weighed. The facility policy and procedure, "Refusal of Care, Treatment and Procedures" dated 12/12/96, indicated the facility will notify the resident's attending physician of refusal of care, treatments or procedures, and will document physician notification in the progress notes.	F 309	notified of any refusals. The audit will be given to the DNS for corrective action. The DNS will provide a summary trends analysis of the audit findings to the CQI committee for further evaluation and/or recommendations.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F323 The ten small oxygen containers have been secured. The Central Supply Director has audited all other oxygen containers to ensure they are secure. The Central Supply Director made corrective action at the time of the audit. The DSD will provide inservice education to the nursing staff and the Central Supply Director on the manufacturer's recommendations that single cylinders should be secured in place or on a cylinder cart so they are not easily knocked over.	7/29/11

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F 323	Continued From page 21 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the resident environment remained free of accident hazards when the Oxygen Room was left unlocked and ten small portable oxygen cylinders were not secured to prevent the cylinders from being knocked over. Findings: During an observation of the Oxygen Room on 6/20/11 at 12:35 p.m., the door labeled Oxygen Room located next to resident room 31 and across from resident rooms 32 and 34 was observed unlocked. Ten small portable oxygen cylinders were observed unsecured in between small portable oxygen cylinders secured in metal racks. During an interview with licensed nurse D (LN D) on 6/20/11 at the same time, she stated the door to the oxygen room should be locked and the tanks should be secured. The manufacturer's recommendations submitted by the facility indicated, in general, store cylinders so they cannot be easily toppled over. Single cylinders should be secured in place or on a cylinder cart so they cannot be easily knocked over. Keep stored cylinders out of high traffic areas.	F 323	On an ongoing basis, the Central Supply Director will conduct a weekly random audit of the oxygen cylinders to ensure they are secured according to the manufacturer's recommendation. The results of the audit will be given to DNS and corrective action will be completed by the Central Supply Director. The Central Supply Director will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluations and/or recommendations.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	F329 Resident 8's physician order for Simvastatin has been clarified to include the indication for use.	7/29/11

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F 329	Continued From page 22 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for two of 15 sampled residents (8 and 9). For Resident 8, there was no indication for the use of Simvastatin in the physicians order per the facility policy. For resident 9, there was no indication for the use of Florastor (probiotic, used to restore normal flora in the intestine) in the physicians order. Findings:	F 329	Resident 9's order for Florastor has been discontinued by the physician. The MRD has audited all other physician medication orders to ensure they include indication for use. The audit was given to the DNS for corrective action. The DSD will provide inservice education to the licensed nursing staff on the facility's policy and procedure for medication orders with an emphasis on making sure that orders include indication for use. On an ongoing basis, the MRD will conduct a random monthly audit of physician orders to ensure they include indication for use. The audit will be given to the DNS for corrective action. The DNS will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 329	Continued From page 23 1. Resident 8 was admitted to the facility with diagnoses including hypertension. According to the Minimum Data Set (MDS) the resident had no cognitive impairment. During record review on 6/22/11 at 8:38 a.m. the 5/10/11 physician's order indicated the resident was to receive "Simvastatin 20 milligrams (a unit of measure) at bed time." There was no evidence on the physician's order or the medication administration record (MAR) dated June 2011 the diagnoses necessitating the order for the Simvastatin. During an interview and record review on 6/22/11 at 8:59 a.m., licensed nurse A (LN A) stated there was no diagnoses for the Simvastatin on the physician's order or the June 2011 MAR. 2. Resident 9 was admitted to the facility with diagnoses including edema (swelling of both ankles) and hyperpotassemia (an abnormally high level of potassium in the blood). The MDS dated 5/31/11 indicated Resident 9 was moderately impaired in cognitive skills for daily decision making. The clinical record was reviewed on 6/22/11. The physician's order dated 1/20/11 indicated Florastor 250 milligrams one tablet by mouth two times a day. There was no indication for the use of Florastor documented on the physician's order. During an interview and record review with licensed nurse C (LN C) on 6/22/11 at 10:55 a.m., he stated he did not know what the medication Florastor was used for and when the order was	F 329		

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F 329	Continued From page 24 written by the physician on 1/20/11 the physician did not document the indication for the use of the medication. After reviewing the uses for Florastor and the physician's orders for Resident 9 he stated on 1/18/11 the physician wrote an order to obtain a stool specimen for c-difficile (bacteria in the intestine) and stool for fecal leukocytes (white blood cells in the stool), so maybe the indication for the Florastor was for that reason. According to www.http://florastor.ca: Florastor enables the body to restore normal flora in the intestine, reducing the risk of antibiotic associated diarrhea. The facility policy and procedure, "Medication Orders" dated 4/2008, indicated: elements of the medication order includes the diagnoses or indication for use.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356	F356 The facility has posted the daily nursing staff data in a prominent place readily accessible to residents and visitors. The facility has posted the name of the facility and the daily census with the daily nursing staff data. The Administrator has audited the daily nursing staffing data to ensure there is no other missing information on the consumer board. The Staffing Coordinator will receive inservice education from the Administrator on the posting requirements for the daily nursing staff data.	7/29/11

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F 356	Continued From page 25 of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post daily nursing staff data in a prominent place readily accessible to residents and visitors. The facility also failed to post the name of the facility and the daily census for the facility. Findings: During an observation on 6/20/11 at 11:35 a.m. and 6/22/11 at 8:30 a.m., the postings of the nursing staff data were observed on the board next to the business office in the corner of the main lobby with all other postings for the facility. There was no name of the facility, daily census or the actual hours per shift worked by licensed nurses or CNAs directly responsible for resident care. During an interview and posting review with the staffing coordinator on 6/22/11 at 8:50 a.m., she stated the "Daily Direct Care Staffing" which listed a total number and hours worked for all	F 356	On an ongoing basis, the Administrator will conduct a random monthly audit of the consumer board to ensure the Staffing Coordinator has posted the required daily nursing staff data on the consumer board. The audit will be given to the Staffing Coordinator for corrective action. The Staffing Coordinator will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 356	Continued From page 26 registered nurses, licensed vocational nurses and certified nurses and certified nurse assistants by shift was posted daily in the morning. She stated the "Daily Direct Care Staffing" is only posted on the board located in the corner by the business office in the lobby and was probably not accessible to residents and visitors. She also stated she was not aware the name of facility and the daily census for the facility needed to be posted.	F 356	F371 The one pound undated plastic bag of zucchini with ice crystals found in the freezer has been discarded. The dietary staff clothing and bags have been removed from inside the pantry and the hooks have been removed.	7/29/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store food under sanitary conditions when open and undated food was found on a resident's bedside table, when staffs' personal belongings were found in the pantry area, and when an undated bag of frozen zucchini with ice crystals was found in the freezer. Findings: 1. During the initial kitchen tour on 6/20/11 at 8:45 a.m., a one pound undated plastic bag containing frozen zucchini slices and ice crystals was found	F 371	The open and undated packages of crackers, cereal, and corn chips have been discarded from the bedside table in Room 7. The bottle of ketchup and mustard have been discarded from Room 24. The DSS has audited the freezer for any undated packages and packages containing ice crystals. No other undated packages or packages with ice crystals were found. The DSS has audited the entire kitchen and pantry area for clothing and bags. The DSS found no other clothing or bags	

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F 371	Continued From page 27 in the freezer. Staffs' jackets and bags was noted on hooks inside the pantry. During an interview on the same date and time the dietary services supervisor (DSS) stated she could not tell how old was the zucchini and the bag should have been dated. The DSS stated staff's clothing should not have been stored in the pantry. According to the 10/1/94 "Nutritional Services Personal Policy and Procedures" all "personal belongings (cigarette packages, sweaters...purses) must be kept in your locker." 2. During the initial tour with licensed nurse A (LN A) on 6/20/11 at 8:20 a.m., open and undated packages of crackers, cereal and corn chips were observed at the bedside in Room 7. The packages were not closed and were opened to the air. In room 24 an open bottle of ketchup and mustard were observed at the bedside. The resident stated the open bottles had been there for a while. The ketchup bottle indicated to refrigerate after opening. During an interview with LN A on the same date and time, she stated she did not know how long the open packages of crackers, cereal and corn chips had been at the bedside, because there was no date indicating when they were opened. She also stated the open bottle of ketchup and mustard were brought in by the resident's family member. The facility policy and procedure, "Food Brought	F 371	being stored in the kitchen or pantry. The Department Supervisors have audited their assigned resident rooms for any open and undated food packages or for food items that require refrigeration. Corrective action was immediately taken by the Department Supervisors. The DSS and DSD will provide inservice education to the dietary staff on labeling and dating of foods in the freezer, on discarding any food packages that contain ice crystals, and on keeping personal clothing and bags in lockers. The DSD will provide inservice education to the licensed nursing staff and CNAs on the facility's policy and procedure for food kept in resident rooms, with an emphasis on refrigerating all foods that require refrigeration and sealing, labeling, and dating all foods.	

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F 371	Continued From page 28 In By Family/Guests" dated 4/1/97, indicated any food left for residents that needs to be refrigerated must be labeled and dated. Consumption of food should be reported to the charge nurse for proper documentation of percent of intake.	F 371	On an ongoing basis, the DSS will conduct a weekly random audit of the freezer to ensure the dietary staff are labeling and dating foods in the freezer, as well as discarding any foods with ice crystals. The DSS will also conduct a weekly audit of the kitchen and pantry to ensure the dietary staff are storing their personal belongings in lockers. The results of the audit will be given to the dietary staff to make corrective action. On an ongoing basis, the Department Supervisors will conduct random weekly audit of their assigned resident rooms to ensure that food kept in resident rooms is being sealed, labeled, and dated and foods that require refrigeration are being kept in the refrigerator. The Department Supervisors will make immediate corrective action and review their audits with the Administrator.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs for two of 15 sampled residents (4 and 14). For Resident 4, the facility failed to ensure medications were coordinated between the facility	F 425		

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F 425	Continued From page 29 and the dialysis clinic prior to dialysis. For Resident 14, the facility failed to ensure medications were received and dispensed in a timely manner. It is important for the facility to coordinate physician's medications orders with the time of dialysis. Dialysis can remove medications from the blood possibly decreasing their effectiveness. Findings: 1. Resident 4 was admitted to the facility with diagnoses including renal failure (kidney failure) and dialysis. The 5/24/11 Minimum Data Set indicated the resident had no cognitive impairment. During record review on 6/20/11 the clinical record indicated the resident attended dialysis on Monday, Wednesday and Friday each week. The physician's medication order indicated nursing was to give the resident Renvela (a medication to reduce the phosphorus level in the blood), Atenolol (a blood pressure medication), Aspirin, and Allopurinol (a medication to decrease the uric acid level, a by product of metabolism) every day. The June 2011 medication administration record (MAR) indicated Resident 4 was given the medications every day in the morning. During an interview and record review on 6/22/11 at 11:10 a.m., licensed nurse E (LN E) stated the resident went to dialysis on Monday, Wednesday and Friday every week in the afternoons. She stated she was unable to locate where the facility coordinated the patient's medication dosing prior to dialysis. 2. Resident 14 was admitted to the facility with diagnoses including elevated blood pressure,	F 425	The DSS and Administrator will provided a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations. F425 The facility has coordinated with the dialysis center to ensure proper dosage and administration of Resident 4's medications. Resident 14 was discharged on 6/14 /11. The IDT has coordinated with the dialysis center on proper dosage and administration of medications for all other residents that receive dialysis. The DNS has audited all new admissions with the past 30 days to ensure that all medications were delivered within a timely manner for those residents. The DSD will provide inservice education to the	7/29/11

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F 425	Continued From page 30 atrial fibrillation (rapid and irregular contractions of the heart), and CHF congestive heart failure. During record review on 6/28/11 at 3 p.m. of the June 2011 MAR (medication administration record) for Resident 14, it indicated several medications were not acquired and administered to the resident on a timely basis. During an interview on 6/24/11 at 10 a.m. licensed nurse A (LN A) stated "after 5 p.m. our pharmacy is closed for new admits to refill all medications in a timely manner." During an interview on 6/24/11 at 10:10 a.m. LN D stated as Resident 14 was admitted to the facility after 5 p.m. when the pharmacy was closed, she did not receive the medications for Resident 14. She further stated some medications arrived at 2 a.m. on 6/14/11 and the balance arrived on 6/14/11 between 1 - 3 p.m. The facility's April 2008 policy, "Medication Orders" indicated for non-emergency medications, the first dose is scheduled when it is due, and after the next regularly scheduled medication delivery to the facility. No specific delivery times were noted.	F 425	licensed nursing staff on coordinating with the dialysis center for proper dosage and administration of medications for residents that receive dialysis. The DSD will provide inservice education to the licensed nursing staff on ensure the timely ordering and delivery of medications for new admissions. On an ongoing basis, the IDT will review residents upon admission and quarterly thereafter that receive dialysis to ensure coordination with the dialysis center for proper dosing and administration of medications. On an ongoing basis, the DNS and/or designee will audit all new admissions with 24 hours of admission to ensure the timely ordering and delivery of medications. The DNS and/or designee with consult with the pharmacy as needed to ensure timely delivery of medications.	
F 428 5/5:D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure irregularities were identified by the pharmacist for two of 15 sampled residents (2 and 7). Resident 7's digoxin level and comprehensive metabolic panel (CMP) and Resident 2's Dilantin level were not drawn as ordered by the physician and not identified as an irregularity by the pharmacist. Findings: 1. Resident 7 was admitted with a diagnoses including muscle weakness, stroke and hypercholesterolemia (increased level of cholesterol in the blood). During record review on 6/23/11 the 5/3/10 physician's order indicated Resident 7 was on Digoxin (a heart medication) 0.25 milligrams (mg. a unit of measure) and Simvastatin (a medication used to decrease the level of "bad" cholesterol in the blood) 80 mg. every day. The physician's order indicated the facility was to obtain a comprehensive metabolic panel (CMP including lipids and liver enzymes) every six months starting 7/19/10 and digoxin level every six months starting 5/3/10. According to www.nzma.org the practice of digoxin therapeutic drug monitoring (TDM) "was introduced more than 30 years ago, and resulted in a marked reduction in the incidence of digoxin	F 428	The DNS will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations. F428 The Consultant Pharmacist has completed a new Drug Regimen Review for Residents 2 and 7. The facility has obtained a new Dilantin level for Resident 2. The facility has obtained a new CMP and Digoxin level for Residnet 7. The MRD has audited all lab orders within the last 30 days to ensure that all labs where drawn and results sent to the physician as ordered. The results of the audit were given to the DNS for corrective action.	7/29/11

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F 428	Continued From page 32 toxicity...symptoms include arrhythmias (abnormal heart beat) and heart block...Digoxin remains a classical drug for which therapeutic drug monitoring may be useful. It has a narrow therapeutic index...TDM may be useful to detect patients with low digoxin concentration and who may benefit from an increase in digoxin dose... " According to manufacturer's instructions Simvastatin therapy includes monitoring "liver enzymes...during treatment...patients on 80 mg. (a unit of measure) should receive more frequent liver function tests...." The same document indicated Simvastatin could cause not only "hepatic (liver) impairment but also renal (kidney) impairment." The last CMP and Digoxin level found in the clinical record was dated 11/5/10. The Digoxin was below therapeutic levels 0.72 (0.9- 2/0 ng ml normal range unit of measure). There was no evidence in the clinical record the facility's pharmacist addressed the missing laboratory data. During an interview and record review on 6/23/11 licensed nurse E (LN E) reviewed Resident 7's clinical record and stated CMP's or digoxin levels due in 2011 were not done. LN E stated the pharmacist did not pick up on the missing laboratory data when he reviewed the resident's monthly drug regime review from 11/1/10 through 5/31/11. According to the consultant pharmacists report policy and procedure dated April 2008 "resident-specific irregularities and/or clinically	F 428	The Consultant Pharmacist will receive inservice education from the Senior Consultant Pharmacist on completing a comprehensive and accurate drug regimen review on a monthly basis. On an ongoing basis, the Senior Pharmacy Consultant will conduct a random audit of the monthly drug regimen review for accuracy and comphrensiveness. The results of the audit will be given to the Consultant Pharmacist for corrective action. The Consultant Pharmacist will provide a summary trends analysis of the audit findings to the CQI steering committee for further evaluation and/or recommendations.	

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F 428	Continued From page 33 significant risks resulting from or associated with medications are documented and reported to the Director of Nursing and/or prescriber as appropriate." 2. Resident 2 was admitted to the facility with diagnoses including elevated blood pressure, and diabetes mellitus II (elevated blood sugar). Record review was done on 6/21/11 at 9:25 a.m. a physician's order dated 3/28/11 indicated decrease "Dilantin to 3 ml po (by mouth) TID (three times a day)" and "Dilantin level in 6 weeks." During an interview on 6/21/11 at 9:10 a.m. licensed nurse A (LN A) stated the Dilantin was not drawn in 6 weeks as ordered by the physician. She further stated this lab was not "captured." During an interview on 6/21/11 at 11:30 a.m. the pharmacist consultant stated, "I agree with you that if we didn't measure [Dilantin level] we wouldn't know for sure." "It appears it [Dilantin level in 6 weeks] was dropped at all angles including myself."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	F441 The facility has cleaned the two oxygen concentrator filters and dated the suction tubing. The DSD/Infection Control Coordinator has audited all other oxygen concentrator filters and suction tubing to ensure they are dust free and dated. Corrective action was taken immediately as needed.	7/29/11

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F 441	Continued From page 34 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a sanitary environment when two oxygen concentrator filters were observed to be covered with dust and suction tubing was not dated. It is important for oxygen concentrator filters to be dust free because the air passes through the filter before	F 441	The DSD will provide inservive education to the licensed nursing staff on ensuring that all oxygen concentrator filters are dust free and the suction tubing is labeled. On an ongoing basis, the DSD/Infection Control Coordinator will conduct a random weekly audit of oxygen concentrators to ensure the filters are dust free and suction tubing is labeled. Corrective action will be taken immediately and the results of the audit will be reviewed with the DNS and/or Administrator. The DSD/Infection Control Coordinator will provide a summary trends analysis of the audit findings of the CQI steering committee for further evaluation and/or recommendations.	

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COUNTRY VILLA WATSONVILLE EAST NURSING CENTER	535 AUTO CENTER DRIVE WATSONVILLE, CA 95076

(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 441	Continued From page 35 the oxygen is removed from the air and delivered to the resident and dust may contain contaminants including fungus. Findings: 1. During the initial tour on 6/20/11 at 8:15 a.m., one non-sampled resident and one sampled resident (8) oxygen concentrator filters were noted to have a layer of dust on them. During an interview and observation with the director of nurses (DON) on the same date and time, she stated the filters needed cleaning. The manufacturer's recommendations for oxygen concentrators indicated oxygen concentrator filters were to be washed once a week with "warm, soapy water and rinsed very well with warm water..." 2. During the initial tour with licensed nurse A (LN A) on 6/20/11 at 8:20 a.m., the following was observed: One non-sampled resident had a suction machine located at the bedside. The tubing connected to the suction machine did not have a date on the tubing indicating when the tubing was placed on the suction machine for use. During an observation and interview with LN A on the same date and time, she stated the tubing looked like it was new, but there was no date on the suction tubing. She also stated the tubing should be dated indicating when the tubing was placed on the suction machine.	F 441	F458 The facility requests to continue the room waiver for Rooms 2 and 17.	7/29/11
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	F 458		

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F 458	Continued From page 36 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 80 square feet per resident in thirty-two resident rooms. (A previous room waiver had been obtained for Rooms 2 and 17.) Having less than 80 square feet per resident could compromise the care of services the residents received. Findings: During an interview on 6/23/11 at 8 a.m. Resident 13 stated, "I feel my room is small. I'm a little nervous about a person who will move in. Hopefully roommate will share space. The TV is on roommate's side. Need permission to use TV." During an observation on 6/23/11 at 12:15 p.m. the maintenance supervisor (MS) and surveyor measured Resident 13's room size. Resident 13's room (a two-person room) measured 140 square feet. This measurement indicated Resident 13's room measured 70 square feet per resident and did not meet the minimum of 80 square feet per resident. During an interview on 6/23/11 at 1:20 p.m. the administrator stated Resident 13's room had "no room waiver." He further stated, "We lost some square foot with the closet space." During an observation on 6/23/11 at 2:30 p.m. all remodeled rooms were measured by the MS with the administrator and surveyor in attendance.	F 458	The facility requests a new room waiver for the additional rooms that fail to meet the 80 square feet per resident requirement. These rooms are 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 18, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29,30, 31, 32, 33, 34,35, and 36. The Administrator will provide a summary trends analysis of the findings to the CQI steering committee for further evaluations and/or recommendations.	

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F 458	Continued From page 37	F 458		

During an observation on 6/24/11 Rooms 1 - 6 were measured by the MS and confirmed with the surveyor. The following measurements indicated rooms did not meet the minimum 80 square foot per resident as they were two-resident rooms. Rooms 1 - 6 had moveable wardrobes which were excluded from useable square footage of the rooms.

Room	Capacity	Square foot/Resident
1	2	73.0
2	2	73.0
3	2	72.0
4	2	73.0
5	2	72.0
6	2	72.0
7	3	77.7
8	2	74.0
9	3	77.7
10	2	76.0
11	2	77.0
12	2	73.0
14	2	70.0
15	2	73.0
16	2	71.0
17	3	74.0
18	3	74.0
19	3	74.0
20	2	76.0
21	3	78.5
23	3	72.0
24	2	73.0
25	3	73.0
26	2	73.0
27	3	72.0
28	2	73.0
29	3	73.0

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F 458	Continued From page 38	F 458		

30	2	70.8
31	3	73.0
32	2	70.8
33	3	73.0
34	2	70.8
35	3	70.5
36	3	72.3

During record review of a letter to the California Department of Public Health from the facility dated 4/18/10 it requested a waiver for Rooms 2 and 17 in regards to the square footage requirement of 80 square feet per resident. Room waivers in effect included only Rooms 2 and 17.

During an interview on 6/24/11 at 8:30 a.m. Resident 13 stated, "If a roommate comes in, I am going to have to ask her permission to use some of her space when I get care. When she gets care, she is going to have to ask me for permission to use my space."

Review of measurements noted on 6/23/11 and 6/24/11 indicated only two of the thirty-six bedrooms provided 80 square feet per resident of useable living space. The two rooms were Rooms 22 and 13.

Variations were in accordance with the particular needs of the residents. Observations showed there was sufficient room for the provision of nursing services and did not compromise the care or services the residents received due to the size of the rooms. Recommend waiver remain in effect.

F514
The facility has communicated to the dialysis center that Resident 4 had developed a wound infection and was on antibiotics.

7/29/11

F 514 SS=D — 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

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F 514	Continued From page 39 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of fifteen sampled Residents' (4 and 14) plans of care and assessments were completed and accurately documented. Resident 4's dialysis communication record lacked documentation the resident had developed a wound infection and was on antibiotics. Resident 14's medication administration record (MAR) was not signed by licensed nurse D (LN D) who administered medications to Resident 14. Findings: 1. During record review on 6/22/11, the 6/13/11 nurse's progress notes at 2:30 p.m. indicated the wound treatment center physician placed Resident 4 on Cipro for wound infection to his left lower extremity every day for 14 days beginning 6/13/11. The 6/2011 medication administration record (MAR) indicated Resident 4 received Cipro at 9:00 p.m. every day beginning 6/13/11 through 6/21/11.	F 514	Licensed Nurse D has documented a late entry to note that the medication was not given. The IDT has reviewed all other residents receiving dialysis to ensure that all current medical information has been communicated to the dialysis center. The MRD has audited the MAR for the past 30 days to identify any missing entries/signatures. The results of the audit were given to the DNS for corrective action. The DSD will provide inservice education to the licensed nursing staff on completing the dialysis communication sheet and ensuring that all current medical information is communicated to the dialysis center. The DSD will provide inservice education to the licensed nursing staff on timely and accurately documenting medication administration in	

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F 514	Continued From page 40 There was no evidence in the "Nurses Dialysis Communication Record(s)" dated 6/13/11 and 6/15/11 the facility notified the dialysis clinic Resident 4 had changes in the past 24 hours and was on antibiotics as prompted by the form under the heading "Changes noted in past 24-48 hours....Antibiotic...new medications, new orders..." There was no evidence in the nurse's notes the facility notified the dialysis clinic the resident had a change in condition and was on antibiotics. During an interview and record review on 6/23/11 at 11:56 a.m. the director of nurses (DON) stated she was unable to locate where nursing documented the dialysis clinic was notified Resident 4 was on antibiotics for a left lower extremity wound infection. During an interview on 6/24/11 at 9:30 a.m., the DON stated she did not have a policy and procedure regarding the "Nurses Dialysis Communication Record." 2. Resident 14 was admitted to the facility with diagnoses including elevated blood pressure. Record review on 6/28/11 at 3 p.m. of Resident 14's 6/2011 MAR indicated Diltiazem (a medication to treat elevated blood pressure) ER (extended release) was not given at 9 a.m. on 6/14/11 as ordered. It also indicated no licensed nurse's initials or signatures were listed on the back of the MAR to identify the nurse administering the medication to Resident 14. During an interview on 6/24/11 at 10 a.m. LN D stated she did not give the Diltiazem and "probably should have signed and circle that it	F 514	the MAR, including circling and indicating reasons for medications not given. On an ongoing basis, the IDT will audit the dialysis communication sheets when a dialysis center resident is reviewed during daily change of condition review to ensure that the licensed nurse has communicated the condition change to the dialysis center. On an ongoing basis, the MRD will complete a random weekly audit of the MAR for missing entries/signature. The result of the audit will be given to the DNS for corrective action. The DNS will provide a summary trends analysis of the audit findings to the CQI committee for further evaluation and/or recommendations.	

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F 514	Continued From page 41 wasn't given awaiting pharmacy notification if ER and SR were the same." The facility policy and procedure dated 2/1/96, "Documentation - Licensed Nurses", indicated "The nurse's full name and title must be written at least once on each page of the medication/treatment record. If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the patient not receiving the medication."	F 514	F518 Licensed Nurse F and CNA G have been inserviced by the DSD on the location of the emergency water. Licensed Nurse F, CNA G, and CNA I have been inserviced by the DSD on how to access the water from the emergency water barrels located in the shed. A sign has been added in the shed to provide instruction on how to access the emergency water from the barrels. The DSD had conducted an audit/quiz of the facility staff to determine which staff members are unable to identify the location of the emergency water and how to access the emergency water from the barrels. Those unable to answer will be provided one on one education from the DSD.	7/29/11
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure two of five staff members interviewed, licensed nurse F and certified nurse assistant G (LN F and CNA G) knew where the emergency water was located. Three of five staff members interviewed, licensed nurse H and certified nurse assistant I and G (LN F, CNA G, and CNA I) did not know how to access water from the 50 gallon barrels located in the shed which was in the back parking lot. Findings: During an interview with LN F on 6/22/11 at 6:45 a.m., she stated the emergency water was located in the staff break room and in the kitchen. She also stated if there were barrels of water in a	F 518		

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F 518	Continued From page 42 shed in the back parking lot she did not know how to access the water from the barrels. During an interview with CNA G on 6/23/11 at 3:30 p.m., she stated the emergency water was located in the employee break room and there was no other water in the facility to use during an emergency. She also stated she was not aware there was water in large 50 gallon barrels and she did not know how to access the water from the barrels. During an interview with CNA I on 6/23/11 at 3:05 p.m., she stated she did not know how to access the water from the 50 gallon barrels located in the shed in the back parking lot. During the environmental tour with the maintenance supervisor (MS) and administrator on 6/23/11 the following was observed: There were 20 five gallon bottles of water located in the employee break room, available for use during an emergency. There were ten 50 gallon blue barrels of water located in the shed in the back parking lot. The administrator stated the ten blue barrels of water were to be used by both the East and the West buildings, five for each building. There were no signs posted to designate how many barrels of water would be used for the East or the West side buildings. When asked how staff would access the water from the barrels, the MS stated there was a wrench to remove the cap and a pump was needed to pump the water out of the barrels. The	F 518	The DSD will provide inservice education to the facility staff on the location of the emergency water and how to access the emergency water. On an ongoing basis, the DSD will conduct a random monthly audit/quiz of the facility staff to ensure they are able to verbalize the location of the emergency water supply and how to access the emergency water. Any staff member consistently unable to verbalize the emergency information will be referred to the Administrator. The DSD will provide a summary trends analysis of the audit/quiz findings to the CQI committee for further evaluation and/or recommendations.	

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F 518	Continued From page 43 MS then removed two boxes labeled Kitchen paper supplies from the top of the blue barrels, found the wrench needed to remove the cap from the water barrels and stated the pump was located in the back of the shed on top of some boxes. There were no instructions for use of the wrench to remove the cap or instructions indicating how to use the pump to access the water from the 50 gallon barrels.	F 518		