STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055491	A. BUILDING _____ B. WING _____	07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK RIDGE HEALTHCARE CENTER	310 OAK RIDGE DRIVE ROSEVILLE, CA 95661

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a recertification survey from 7/6/15 through 7/9/15. Representing the Department of Public Health: HFEN - 34328 HFEN - 29583 HFEN - 35599 HFEN - 31321 RD consultant-31472 Pharmacy consultant - 35335 The facility census was 54 and the sample size was 14	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because its required by the rpovisions of Health and Safety Code Section 1280 and 42 CFR 405.1907. "This Plan of Correction constitues my written credible allegation of compliance for the deficienciesnoted"	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 3 out of 14 sampled residents (6,7,9) and one random resident (16) was adequately assessed for pain control. This failure placed residents at risk of maintaining their highest practicable physical, mental and psychosocial well being.	F 309	**F 309** A- Oak Ridge Healthcare Center does provide care/services for the highest well being. 1-Resident 6 care plan was adjusted by physician on 7/13/15 to reflect current need. 2-Resident 7 was discharged on 7/29/15. 3-On 7/6/15 the physician and interdisciponary team reviewed the residents pain management. The pain meds were being given just not documented. 3- On 7/6/15 the physician and interdiscplinary team reviewed resident 9's pain management. Orders were clarified. The Tramadol 50 mg BID was changed from PRN to a routine order. Ibuprofen 400mg Q6 hrs PRN was added for breaktrhough pain 4- Random resident 16 was reviewed by the physician on 7/9/15. Any necessary adjusments were done at that time.	8/9/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Dillard — TITLE: Administrator — (X6) DATE: 7/29/15

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

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F 309	Continued From page 1 Findings: 1. Resident 6 was admitted to the facility in the Fall of 2010 with diagnoses that included a decubitus ulcer. A review of the annual Minimum Data Set (MDS, an assessment tool) dated 4/9/15, indicated the resident was assessed to understand others and be understood. She had a Brief Interview for Mental Status of 3/15, which indicated she was not cognitively intact. A review of the care plan for Resident 6 indicated, "Evaluate resident's verbal and non-verbal cues to assess the degree and severity of pain," and "Assess appropriateness of pain medication." A review of the physician's orders from February 2015 through July 2015, indicated the following pain medication orders to be administered without indicating if it should be administered for mild, moderate or severe pain. Nor was there a pain scale found; Tylenol 325 milligrams (mg, a unit of measure) 1 PO (by mouth) every 4 hours prn (as needed) for pain, Duragesic patch 12 mcg (microgram, a unit of measure) every 72 hours for pain management, and, Roxanol 20 mg/1 ml (milliliter) give 0.25 ml po every 4 hours prn pain A review of the Medication Administration Records dated February 2015, March 2015 and April 2015 indicated Resident 6 received pain medication for 9 weeks without an indication for the type of pain it was being administered for or how effective it's use was. A review of the facility's policy and procedure	F 309	**B-** The Director of Nurses reveiwed the orders for the other residents and no others were found to be affected **C-** On 7/29/15 the licensed nurses were in-serviced by the Director of Nurses. The topics included pain management and documentation of pain assesment. The physician and pharmacy consultant will review all facility residents each month for compliance. Medical records will also perform monthly audits to make sure the necessary documentation is completed. **D-** All his findings will be presented to the Continuing Quality Improvement Team for review and recommendation	

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F 309	Continued From page 2 titled, "Pain Assessment and Management," revised 2009, stipulated, "Pain management is a multi-disciplinary care process that includes the following: Assessing the potential for pain, Effectively recognizing the presence of pain, Identifying and using specific strategies for different levels and sources of pain; monitoring for the effectiveness of interventions...the following equipment will be necessary when performing this procedure...pain assessment tool...Monitor the resident by performing a basic assessment with enough detail and, as needed with standardized assessment tools (e.g., approved pain scales, etc) and relevant criteria for measuring pain management." In an interview with licensed nurse (LN) 2 on 7/9/15 at 10:34 am, he stated, "We use the mild, moderate, severe scale...We used to use the pain scale. I don't know why we don't anymore. We should have something more specific like the pain scale." 2. Resident 7 was admitted to the facility in the Winter of 2008 with diagnoses that included; osteoarthritis/degenerative joint disease. The annual MDS dated 4/23/15 indicated the resident was understood by others and was able to usually understand others. A review of the physician's orders from May 2015 through July 2015, indicated the following pain medication orders to be administered without indicating if it should be administered for mild, moderate or severe pain. Nor was there a pain scale found. Tylenol 325 milligrams (mg) 1 PO (by mouth) every 4 hours prn (as needed) for pain Neurontin 600 milligram 1 po bid (twice a day) for	F 309		

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F 309	Continued From page 3 neuropathy pain. A review of the care plan titled, Alteration in comfort: Pain and discomfort related to Alzheimer's Disease and dated 12/10/08, indicated, "Assess appropriateness of pain medication." A review of the Medication Administration Records from May 2015 through July 2015 indicated Resident 7 received the Neurontin for pain control, but there was no indication for it's effectiveness. A review of the facility's policy and procedure titled, "Pain Assessment and Management," revised 2009, stipulated, "Pain management is a multi-disciplinary care process that includes the following: Assessing the potential for pain, Effectively recognizing the presence of pain, Identifying and using specific strategies for different levels and sources of pain; monitoring for the effectiveness of interventions...the following equipment will be necessary when performing this procedure...pain assessment tool...Monitor the resident by performing a basic assessment with enough detail and, as needed with standardized assessment tools (e.g., approved pain scales, etc) and relevant criteria for measuring pain management." In an interview with LN 2 on 7/9/15 at 10:34 am, he stated, "We use the mild, moderate, severe scale...We used to use the pain scale. I don't know why we don't anymore. We should have something more specific like the pain scale." 3. Resident 9 was admitted to the facility in the Summer of 2015 with a diagnoses that included;	F 309		

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F 309	Continued From page 4 stroke. The initial MDS dated 7/1/15 indicated the resident was assessed as being able to be understood as well as able to understand others. A review of the physician's orders from June 2015 through July 2015, indicated the following pain medication orders to be administered without indicating if it should be administered for mild, moderate or severe pain. Nor was there a pain scale found. Tylenol 325 milligrams (mg) 1 PO (by mouth) every 4 hours prn (as needed) for pain and, Tramadol 50 mg po bid prn pain A Pain Care Plan dated 6/26/15 indicated, "Assess type and degree of resident pain." A Physical Therapy evaluation dated 6/25/15-7/1/15 , indicated, "Pre-med for left hand/wrist pain works when before PT treatment." A nurse's note dated 7/1/15 indicated, "Pt. [patient] c/o [complains of] frequent pain to left hand, states,'Tylenol doesn't work.' MD notified. N.O. [new order] noted for tramadol." A review of the Nurses Medication Notes indicated the resident received tramadol prn from 7/1/15, 3, 4, 6, 7 through 7/9/15. The resident also continued to receive Tylenol even though he stated it did not help him, on 7/6/15 and 7/8/15. A review of the facility's policy and procedure titled, "Pain Assessment and Management," revised 2009, stipulated, "Pain management is a multi-disciplinary care process that includes the following: Assessing the potential for pain, Effectively recognizing the presence of pain, Identifying and using specific strategies for	F 309		

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F 309	Continued From page 5 different levels and sources of pain; monitoring for the effectiveness of interventions...the following equipment will be necessary when performing this procedure...pain assessment tool...Monitor the resident by performing a basic assessment with enough detail and, as needed with standardized assessment tools (e.g., approved pain scales, etc) and relevant criteria for measuring pain management." In an interview with LN 1 on 7/9/15 at 10:47 a.m., she stated, "If the resident has two prn medications ordered, but having ongoing pain, I would call the doctor." There was no documentation found in the chart which indicated the Resident's doctor had been contacted regarding the ongoing pain, or any changes made to the "prn" orders. 4. Random Resident 16 was admitted to the facility in Summer 2015 with diagnoses that included; stroke. A review of the Medication Record for June and July 2015 indicated the resident had the capacity to understand choices and make medical decisions. The following medications were ordered for pain; Dilaudid 4 mg 1 po tid (three times a day) for pain management, Neurontin 300 mg 1 po tid for radiculopathy (pain from the nerves) pain and, Tylenol 325 mg 1 po every 4 hours prn pain There was no indication if these pain medications should be administered for mild, moderate or severe pain, nor was a pain scale found. During Med Pass on 7/7/15 at 8:16 a.m., the	F 309		

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F 309	Continued From page 6 Random Resident 16 asked LN 2 about his pain medication and stated, "The dilaudid isn't working. I like the shot. Pills don't work. I told you guys this before!" A review of the facility's policy and procedure titled, "Pain Assessment and Management," revised 2009, stipulated, "Pain management is a multi-disciplinary care process that includes the following: Assessing the potential for pain, Effectively recognizing the presence of pain, Identifying and using specific strategies for different levels and sources of pain; monitoring for the effectiveness of interventions...the following equipment will be necessary when performing this procedure...pain assessment tool...Monitor the resident by performing a basic assessment with enough detail and, as needed with standardized assessment tools (e.g., approved pain scales, etc) and relevant criteria for measuring pain management." In a concurrent interview with LN 2 on 7/7/15 at 8:16 a.m., he stated, "We don't do pain levels [scales]. We assess the patient using mild, moderate or severe."	F 309		8/9/15
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by:	F 360	**F 360** **A:**On 7/9/15 the Dietary Manager updated the clinical record to reflect the correct diet/allergies. **B:**On 7-9-15 the Dietician reviewed all charts. No other charts were found to be not in compliance.	

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F 360	Continued From page 7 Based on observation, interview, and record review, the facility failed to provide special dietary needs for 1 of 14 sampled residents (10) when the facility did not assess, document, and communicate Resident 10's food allergies to dietary services. This failure put Resident 10 at risk for mild to severe allergic reaction. Findings: Resident 10 was admitted to the facility with multiple diagnoses. A review of Resident 10's Minimum Data Set (MDS, an assessment tool) revealed a BIMS (brief interview for mental status) of 5 out of 15. This indicated Resident 10 was severly cognitively impaired. A review of Resident 10's admission paperwork received from an acute care facility titled, "Inter-facility Transfer Report," dated 4/21/15, in the section, "Allergy History as of 4/20/15," indicated Resident 10 was allergic to: penicillin (an antibiotic, PCN); strawberry; peanut flavor, peanut oil." A review of Resident 10's clinical record titled, "Dietary Order and Communication" dated 4/21/15, revealed licensed nurse (LN) 5 did not indicate any food allergies. A review of Resident 10's Hospice medication record dated 4/22/15, revealed LN 6 indicated the resident was allergic to: peanut butter flavor; penicillin; peanuts; strawberries, and almonds. A review of Resident 10's clinical record titled, "Hospice Progress Note" dated 4/22/15, revealed	F 360	**C:** On 8/3/15 the Dietician in-serviced the Dietary Manager. The topic included charting, and accurate ressident assesments. **D:** The Dietician will review random charts during her monthly visits to ensure compliance. The findings will be reported to the Continuing Quality Improvement Team for review and recommendation.	

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F 360	Continued From page 8 LN 6 documented, "...coordinated care with LN 7. Reconciled [Resident 10's] medications." A review of Resident 10's clinical record titled "Registered Dietician Nutrition Assessment" dated 4/28/15, revealed the registered dietician (RD) indicated no known food allergies. During a telephone interview with LN 6 on 7/8/15 at 12:40 p.m., LN 6 stated that Resident 10's allergies were true allergies and not dislikes. She also stated a list of Resident 10's medications and allergies were placed in her clinical record. In an interview with Resident 10 on 7/8/15 at 1:45 p.m., she stated she broke 'breaks' out in a rash if she ate 'eats' bananas, almonds, strawberries or peanuts. A review of Resident 10's medication administration record (MAR), indicated the only allergies listed were: 4/1/15-4/30/15: PCN 5/1/15-5/31/15: PCN 6/1/15-6/30/15: PCN 7/1/15-7/31/15: PCN A review of Resident 10's physician orders, dated 7/1/15 and the MAR, dated 7/1/15, indicated there were no active orders for epinephrine or another antihistamine (both are used to treat allergic reactions). Resident 10's care plan did not include plans for allergic reaction and interventions to implement. In an observation and interview on 7/8/15 at 2 p.m., the director of nursing (DON) stated that allergies are supposed to be on the front of the	F 360		

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F 360	Continued From page 9 chart and the face sheet. The DON validated the findings. She further stated they [nurses] should be documenting the allergies on the admission. During an interview with the minimum data set coordinator (MDSC) on 7/9/15 at 12:20 P.M., the MDSC confirmed that Resident 10's allergies were not accurately listed on the face sheet, MAR, and care plan. Review of the facility's policy and procedure titled "Admission Assessment and Follow up: Role of the nurse," the policy indicated, "...Conduct an admission assessment (history and physical), including: A summary of the individual's recent medical history, including hospitalizations, acute illnesses, and overall status prior to admission...Current medications and treatments...Contact the attending physician to communicate and review findings of the initial assessment and any other pertinent information and obtain admission orders that are based on assessment findings...Notify other disciplines and departments of the resident's admission, including:.. Dietary." A review of the facility's policy and procedure titled "Food Allergies and Intolerances" (revised December 2008) indicated, "Residents with food allergies and/or intolerances will be identified upon admission and steps will be taken to prevent resident exposure to the allergen(s) (a substance that causes an allergic reaction)...Assessment and Intervention: ...Residents will be assessed for history of food allergies and intolerances upon admission...All residents reported food allergies and intolerances will be documented in the assessment notes and incorporated into the resident's care plan...The	F 360		

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F 360	Continued From page 10 attending physician will be notified of the resident's food allergies and standing orders for emergency medications (example given: epinephrine; and/or a antihistamine) and interventions will be taken...If a resident reacts to a food allergen, appropriate medications and/or interventions will be administered per standing orders and according to the severity of the reaction." In a concurrent observation and interview with the RD and the DM 7/9/15 at 12:35 p.m., the RD stated the assessment was filled out by the DM and she co-signed the assessment. She further stated she had reviewed the chart from front to back and missed the information. The RD further indicated, "We dropped the ball. I freely admit we should've picked up on this information. The allergies should've been listed on the tray line card. I get my information from the chart and the [facility] admission packet."	F 360		
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 facility	F 371	F 371 **A: 1**-On 7/6/15 the nectar thickened item was disposed of. **2**- The ice machine was wiped down on 7/6/15 and cleaned. A new plastic front was ordered and installed on 7/29/15 by the maintenance supervisor. **3**-The maintance supervisor began sanding and painting the cabinets on 7/15/15. And fixed the gap. **4**-On 7/6/15 the undated food items were dated by the Dietary Manager. **5**-The staff member with acrylic nails put gloves on. The dietary manager disposed of the ice and and made sure anyone with acrylic nails had gloves on. After this no other residents were found to be affected.	8/9/15

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F 371	Continued From page 11 record review, the facility failed to ensure food was stored and served under sanitary conditions when: 1. An expired food item was stored in the walk-in refrigerator. 2. The ice machine had a black substance on the inside door and a torn/cracked plastic edge. 3. The kitchen cabinet doors, drawers, door jamb and walls had chipped, flaking paint, and exposed wood and dry wall, and a large gap, measuring approximately two inches by twelve inches, between the splash board and the wall, 4. The facility failed to label and date stored food items in freezer #2 and, 5. A kitchen staff with acrylic nails prepared food without wearing protective gloves. These failures had the potential to cause cross-contamination and food-borne illness in residents who received their meals from the kitchen for a census of 54. Findings: 1. During the initial kitchen tour on 7/6/15 at 8:09 a.m., an expired product of nectar thickened (for residents with swallowing problems) carbonated beverage was stored in the walk in refrigerator. The taped label on the top of the container was marked 7/2/15. Review of the facility's document titled "DRY GOODS STORAGE GUIDELINES" (dated 3/13), under the "Opened, Refrigerate" category indicated, "Carbonated beverages are to be discarded after 2 days/closable container." In a concurrent interview with the DM on 7/6/15 at 8:09 a.m., the DM confirmed the finding and	F 371	**B:** On 7/6/15 the Dietary Manager checked and no other expired items were found. We only have one ice maker. No other cabinets were found to need repair. No other items were undated and no other staff members has acrylic nails. **C:** The dietary Manager did an in-service on 8/3/15. The topics included; Glove use, kitchen sanitation and labeling and dating.The Administrator spoke with the Maintenance supervisor regarding making sure the kitchen was in good repair. **D:** The Dietary Manager will monitor on a daily basis to ensure expired items are disposed, food items are labeled and dated, and the proper sanitation protocol is being followed. The Dietician will perform random audits during her monthly visits. The Maintenance Supervisor will include in his rounds to inspect the kitchen for repairs. The findings will be reported to the Continuing Quality Improvement Team for review and recommendation	

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F 371	Continued From page 12 stated, "We are supposed to be throwing that out after three days." 2. During an observation of the the ice machine on 7/6/15 at 8:45 a.m., with the DM, it was observed to have a torn piece of plastic on the inside, exposed to the ice. It had an exposed jagged edge. A small piece of tan moist cloth was caught on the jagged edge. A white towel wipe test (a moist paper towel used to wipe) of the inside door of the ice machine revealed a black substance. In a concurrent observation and interview on 7/6/15 at 8:45 a.m., the DM validated the findings. According to the Federal Food Code 2013, equipment such as ice bins and enclosed components of equipment such as ice machines, surfaces shall be cleaned at a frequency necessary to preclude accumulation of soil or mold. During an interview with the maintenance supervisor (MS) on 7/8/15 at 9:40 a.m. the ice machine was observed. The MS confirmed the finding and stated, "No it [the torn edge of the ice machine] should not be like that. Of course not." 3. During the initial kitchen tour on 7/6/15 at 8:09 a.m., the cabinets, nearest the stove, had chipped, flaking paint, and exposed wood with doors that did not align to allow full closure. The drawers closest to the double sink did not align to allow full closure. The drawer to the right of the sink had the front falling off. The door jamb leading to the employee break room had paint chipped away with a large vertical area of exposed rough wood (measuring approximately	F 371		

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	055491	A. BUILDING _____ B. WING _____	07/09/2015

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F 371	Continued From page 13 12 x 6 inches). The wall to the right of the employee break room door jamb had a large section of exposed drywall, and a gap (measuring approximately two inches by twelve inches) between the splash board and the wall nearest the walk-in refrigerator. During an interview on 7/6/15 at 1:30 p.m., the MS stated he is aware of the kitchen problems. In a subsequent interview on 7/7/15 at 9:45 a.m., the administrator (ADM) confirmed there was no active work order and or a timeline for the work to be completed on the kitchen. According to the Federal Food Code 2013, for durability, "Equipment must be constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms (bacteria than can cause illness), insects, and rodents." According to the Federal Food Code 2013, for cleanability, "Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms (thin, slimy film of bacteria that adheres to a surface). Once established these biofilms can release pathogens into food. Biofilms are highly resistant to cleaning and sanitizing efforts." 4. During initial kitchen tour on 7/6/15 at 8:45, freezer #2 had 34 unlabeled bags of meat/food product removed from their original packaging.	F 371		

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F 371	Continued From page 14 Two additional bags; one of a meat product and one of bread, were not dated or labeled. A sign posted on freezer #2 indicated, "Please label and date anything you put in the freezer." In a concurrent interview on 7/6/15 at 8:45 a.m., the DM and the RD confirmed the finding. The DM stated, "We are supposed to date and label products." In review of the undated facility policy titled, "Procedure for Freezer Storage" indicated "...All frozen food should be labeled and dated..." According to the F.D.A. (Food and Drug Administration) food code 2013, items removed from their original package must be labeled with their common name. 5. During tray line observation on 7/7/15 at 11:15 a.m., Cook 1 had an acrylic (artificial) nail application and was observed preparing food without protective gloves. She also placed her bare hand under the dome lid of the blender and her fingers mingled (mixed) with the food on the dome lid. In review of a dietary in-service on 6/24/15 titled, "Food safety-Preventing Food-Borne Illness Fire Safety," the hand out titled, "Personal Hygiene Proper Attire" indicated, "...Artificial nails are not allowed in the dietary department unless approved by the facility." According to the food code 2013, "Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food."	F 371		

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F 371	Continued From page 15 In a concurrent interview on 7/7/15 at 11:15 a.m., the RD validated the finding and stated the cooks are to wear gloves if they have artificial nails.	F 371		
F 431 SS=D	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 reconciliation; and determines that drug 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.	F 431	**F431** A: On 7/8/15 the Director of Nurses checked the medication carts and the medication room for any discontinued /Expired medications. No other issues were found. The Director of Nurses reordered the E-kit the same day **B:** The Director of Nurses inspected the med room and carts and found no other medications to be expired or discontinued. **C:** The Director of Nurses in-serviced all licensed nurse on 7/29/2015. One of the topics included medication Storage/ Emergency Kits. The Licensed nurse will pull out of the medication cart, all discontinued medication, as soon as she/he received the order to discontinue the medication. The medication will be put in Med Room in the space created for discontinued medication. The DON will check the e-kits once a week for intact seals and pick up the discontinued medication. **D:** During the monthly visits the pharmacy consultant will check the medication room, the E-Kits, medication carts to ensure compliance. All findings will be presented to the Continuing Quality Improvement Team for review and recommendation	8/9/15

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F 431	Continued From page 16	F 431		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to store medications properly for a census of 54 when an expired IV antibiotic was not removed from the med room, and when a medication was not re-ordered from the emergency kit within 72 hours. This failure had the potential to adversely affect residents who may be administered expired medications or receive delayed treatment due to medications not replaced in a timely manner.

Findings:

1. During an inspection of the Medication Room on 7/8/15 at 2:20 p.m., 2 bags of IV cefepime 200 milliliters (an antibiotic), was observed in the medication refrigerator. The label indicated the medication had been refilled on 5/24/15 and expired on 5/31/15.

In a concurrent interview with the Director of Nurses on 7/8/15 at 2:20 p.m. she confirmed the antibiotic should have been discarded already.

2. During an inspection of the Medication Room on 7/8/15 at 2:20 p.m., the narcotics emergency kit in the refrigerator was noted to have been opened on 6/12/15 and a bottle of ativan (medication used to treat anxiety and insomnia) had been removed.

A review of the facility policy and procedure titled, Emergency Drug Kit, stipulated, Emergency box

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F 431	Continued From page 17 seals are to be checked each shift by the oncoming charge nurse to ensure seal has not been broken...The box must be replaced within 72 hours...The charge nurse shall notify the Pharmacist immediately when drugs have been used from the emergency kit, or when the seal has been broken...The supply shall be checked monthly by the consultant pharmacist. In a concurrent interview with the Director of Nurses on 7/8/15 at 2:20 p.m. she confirmed the charge nurse should have alerted the pharmacy. In an interview with the Pharmacy Consultant on 7/9/15 at 9:20 a.m., he stated, "I didn't check the refrigerator narcotics box [6/25/15]. I missed it."	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility failed to accurately document and maintain	F 514	**F514** **A: On 7/8/15 the Director of Nurses met with the RNA to review residents 4 orders. Any notes that could be corrected as late entry were.** **B: On 7/8/15 the Director of Nurses reviewed the other RNA records and no others were found to be affected.** **C: The Director of Nurses in-serviced the RNAs on 7/29/15. The in-service included following the MD order, proper documentation, following the facility protocol.** Including if the resident refused the treatment, the reason(s) why and signature of person recording the data. Medical Records will do monthly audits to ensure compliance. The Director of Nurses will follow up with any discrepancies.	8/9/15

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F 514	Continued From page 18 treatment records for 1 of 14 sampled residents (4). This failure had the potential of Resident 4 not receiving accurate treatment and care as ordered. Findings: During a review of Resident 4's physician's order dated on 5/28/15 indicated, "RESTORATIVE AIDE TO PROVIDE: AMBULATION w/ [with] FWW [Front Wheel Walker] 75 to 150 feet X2 [times two], w/ CGA [Caregiver Assist]/SBA [Standby Assist] 5X [five times] WK [Week]." During a review of Resident 4's Restorative - Charting Record for June, 2015 the charting record revealed missing Rehabilitation Nursing Assistant (RNA) initials on the following dates: 6/1/, 6/8/, 6/15/, 6/21/ and, 6/29/15. Resident 4 had received 15 documented RNA treatments out of an expected 20 treatments for the month of June, 2015. During an interview with the Director of Nursing (DON) on 7/5/15 at 1 p.m., she confirmed that there should have been a signature when a resident is seen by an RNA and if the RNA could not do the RNA they are to document on the RNA sheet the reason why it wasn't done, they (RNA) are to document on the RNA sheet the reason why it wasn't done. If a resident refuses, it must be documented. If resident refuses, it must be documented. There are no circle the date the missing treatment wasn't done and reason for why it wasn't done. She stated that the RNA should have documented per facility practice. If she (RNA) did not sign the record then the	F 514	**D:** The findings will be reported to the Continuing Quality Improvement Team for review and recommendation	

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F 514	Continued From page 19 therapy did not occur. In an interview and clinical record review with RNA 1 on 7/8/15 at 12:10 p.m., Resident 4's Restorative Charting record for June, 2015 was discussed and reviewed. She confirmed that RNA therapy sessions dated 6/1, 6/8, 6/15, 6/21 and 6/29/15 were not initialed nor were the dates encircled. That indicated that therapy did not occur. RNA 1 confirmed Resident 4's RNA progress notes had no written indications why therapy did not occur. RNA 1 confirmed Resident 4's June, 2015 Restorative treatment record indicated a total of 15 RNA therapy sessions were completed out of an expected 20 RNA sessions. RNA 1 stated that Resident 4 had not received the correct number of treatments for June, 2015.	F 514		