Reviewed & accepted
dgerstaw, RN 6/7/12

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

PRINTED: 05/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056458	A. BUILDING _____ B. WING _____	05/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF SOUTH GATE	8455 STATE STREET SOUTH GATE, CA 90280

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Re-certification survey. Representing the Department of Public Health: [redacted] RN, HFEN [redacted] RN, HFEN [redacted] REHS, HFE I Total Resident Population: 69 Total Resident Sample Size: 15 Highest Scope and Severity: E	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged on conclusion set forth on the statement of deficiencies. This plan of correction prepared pr executed solely because it is required by the provisions of Health & Safety Code Sections 1280 & 42 CFR 483 et seg. This plan of correction serves as our written credible allegation of compliance for the deficiencies noted. RECEIVED 2012 JUN -7 PM 1:38 HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically-related social services for one of 15 sample residents (10). For Resident 10, social services failed to arrange a dental consultation due to ill-fitting dentures. This deficient practice resulted in delay in readjustment/fitting of the resident's dentures. Findings:	F 250	Social Service Designee called the son and requested him to bring resident #10 dentures to the facility. Furthermore, she immediately contacted and arranged dental consultation for resident #10 on 05/18/12. Dental Consultation scheduled for 06/05/12. Meanwhile, resident continues to have puree diet which she is tolerating well. Resident has no weight lost since admission to date. Social Service Designee reassessed and checked all residents who has denture to find out if any other resident is affected by the same problem as that resident #10 for immediate intervention. None was noted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	06/07/12

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

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F 250	Continued From page 1 On 5/16/12, at 12:15 p.m. during a dining observation, Resident 10 was observed in the restorative nursing assistant (RNA) program dining area, eating by herself with supervision. The resident's lunch consisted of pureed food. On 5/18/12, at 12:35 p.m., the resident was eating her lunch with the assistance of the activity director, who served as interpreter. At the time of the observation, during an interview, the resident indicated she did not have any teeth and needed new dentures, but could not afford them. She then stated she had not used her dentures in several years because they did not fit properly. A review of the clinical record disclosed the resident was admitted to the facility on 3/05/12, with diagnoses that included dementia, high blood pressure and anxiety. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 3/17/12, indicated the resident had periods of confusion and required minimal to extensive assistance with most of her daily living activities. The Nutritional Assessment form dated 3/6/12, documented the resident had a mechanical soft diet due to problems with chewing. An entry dated 3/12/12, indicated to change diet to pureed, due to difficulty eating a mechanical soft diet. The Social Services Assessment form dated 3/8/12, indicated the resident had a full set of dentures, but the resident's family member informed the social services designee (SSD) that the resident had not used them in five or six years and was able to eat without them. On 5/18/12, at 12:45 p.m., during an interview,	F 250	Administrator reemphasized and rein-serviced Social Service Designee to be consistent assessing resident to ensure that all psychosocial services and needs are provided. It included but not limited to dental needs such as dental consultation and dentures. DON, DSD and Social Service Designee will monitor during meal time when resident is eating to find out if he/she has difficulty in eating secondary to having no denture or needing dental consultation for fitting adjustment. CNA will monitor while assisting resident during meal time and report to License Nurse if any resident is noted with problem. IDT will monitor during weekly resident care conference where resident concerns are reviewed and updated. QA will be done monthly to check the effectiveness of system.	05/22/12

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F 250	Continued From page 2 the SSD confirmed she did not make arrangements for a dental consultation for the resident. The SSD also indicated there was a possibility the resident's dentures could be refitted.	F 250		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary treatment and services to prevent the development of pressure sores, promote healing and prevent infection, for two of 15 sample residents (7, 1). Resident 7, who had a history of redness on the heels, was not wearing heel protectors when in bed in accordance with the care plan and physician's order. Resident 1's heels were not off-loaded from the bed in accordance with the care plan. Additionally, the treatment nurse failed to wash his hands during wound treatment. This deficient practice had the potential for pressure sore development and wound contamination. Findings:	F 314	DON and Treatment Nurse immediately reassessed resident #7 and heel protectors were immediately applied to both heels. While resident #1 foam pillow was put under resident legs to keep the heel off pressure from bed. 05/16/12 CNA assigned to both residents were immediately confronted by DSD and rein-serviced regarding the vital importance of applying pressure relieving devices to resident such as heel protectors or foam pillow. DON called the attention of the Treatment Nurse concern regarding compliances on handed washing protocol according to CDC guideline during treatment. DON, DSD and treatment nurse made round to find out if any other resident who could be affected by the same problem as that of resident #7 and #1 for immediate intervention. DON and DSD made round to find out if treatment nurse and other license nurse complied with hand washing protocol according to CDC guideline for immediate redirection.	

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F 314	Continued From page 3 1. A review of the clinical record revealed Resident 7 was admitted to the facility on 10/3/11, with diagnoses that included dysphagia (difficulty swallowing), status post gastrostomy tube (GT - tube surgically inserted through the abdominal wall into the stomach for the purpose of nutrition and medication administration) placement and anemia. The quarterly Minimum Data Set (MDS - standardized assessment and care planning tool) dated 4/13/12, indicated the resident had impaired cognitive skills in daily decision-making and was totally dependent on staff for activities of daily living (ADLs). A physician's order dated 10/3/11, indicated to apply both heel protectors when in bed. A care plan with a re-evaluation dated 7/2012, developed for the resident's risk for skin breakdown, skin discoloration and skin tears indicated in the approaches to apply heel protectors when in bed. During multiple observations from 5/15/12 through 5/16/12, the resident was not wearing heel protectors when in bed. On 5/16/12, at 3 p.m., after checking the resident's feet while the resident was in bed, Certified Nursing Assistant 1 (CNA 1) stated she did not know if the resident should be wearing heel protectors. CNA 1 explained the charge nurse would tell her if the resident needed to wear them. After searching the resident's bed area and closet, there were no heel protectors found. At 3:05 p.m., during an interview, the treatment nurse, Licensed Vocational Nurse 2 (LVN 2)	F 314	DSD rein-serviced CNAs regarding close observation of the resident while providing the care and to report to charge nurse any change of condition noted. It include but not limited to resident with skin discoloration / redness especially heel, buttock and coccyx areas and the like. And make sure that resident with special pressure relieving device are apply such as heel protectors or foam pillows etc. Report should be done to charge nurses if resident had no pressure relieving device if he/she need one. DON rein-serviced license nurses on the "must" of complying and applying CDC guideline regarding protocol hand hygiene including but not limited hand washing especially during treatment. It is important to hand wash after removing any form of material offering protection such as dressing, gauze and the like. DON and DSD will monitor during their daily round while license nurse Q shift during medication pass or treatment by checking resident with pressure relieving device order to ensure such are complied with. DON and DSD will check license nurses daily during treatment to find out if they are practicing hand hygiene according to CDC guideline in hand washing protocol. QA will be done monthly to check the effectiveness of system.	05/22/12 05/22/12

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F 314	Continued From page 4 stated the resident needed to wear heel protectors for maintenance of skin integrity because he had a history of redness on his heels. LVN 2 explained the CNA assignment book should indicate any extra treatment and services the resident needed. However, after reviewing the CNA assignment book, there was no indication the resident needed heel protectors when in bed. 2a. A review of the clinical record revealed Resident 1 was readmitted to the facility on 3/6/12, with diagnoses that included recent history of pneumonia, history of stroke with dysphagia, Stage I sacro-coccygeal (tailbone) pressure sore (a defined area of persistent redness) and Stage III pressure sore (full-thickness tissue loss; may include undermining and tunneling) to the right heel. The MDS assessment dated 5/7/12, indicated the resident was severely cognitively impaired, was incontinent of bowel and bladder and was totally dependent on staff for all of her ADLs. The Pressure Ulcer Risk Assessment, updated 4/12/12, indicated the resident was high risk for pressure ulcers. A care plan developed on 2/26/12, for the resident's risk for further skin breakdown, included an approach plan to keep pressure off affected areas. During an observation on 5/16/12, at 8:55 a.m., the resident was lying in bed, awake, restless and did not respond to her name. A foam pillow (to off-load pressure areas) was located at the head of the bed, instead of under the resident's legs/feet. At 1:55 p.m. and at 3 p.m. the same day, the resident was observed asleep in bed. The foam	F 314		

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F 314	Continued From page 5 pillow was observed on the resident's chair. On 5/16/12, at 3 p.m. during an interview, CNA 2 stated the pillow was supposed to be placed under the resident's legs in order to keep the heels off the bed and prevent pressure on the heels. 2b. On 5/17/12, at 10:10 a.m., during observation of Resident 1's Stage III right heel pressure sore, the treatment nurse removed the soiled dressing, removed his gloves, applied new gloves, then cleaned the wound with normal saline solution and gauze. He then removed and replaced gloves, applied treatment ointment, changed gloves, applied a dry dressing, then secured the dressing with gauze and washed his hands. The treatment nurse failed to wash his hands during the course of the wound treatment. On 5/17/12, at 12:10 p.m., during an interview, the treatment nurse stated he should have washed his hands after removing the soiled dressing, prior to cleansing the wound and applying the ointment, and prior to application of the dry dressing, in order to prevent wound contamination. According to the CDC.gov website Protocol for Hand Hygiene, the use of gloves does not replace the need for cleaning hands. Discard gloves after each task and clean hands. Hand hygiene should be performed after removing any form of material offering protection (napkin, dressing, gauze, sanitary towel, etc.)	F 314		
F 322 SS=E	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322		

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F 322	Continued From page 6 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a resident who is fed by a gastrostomy tube (GT - tube surgically inserted into the stomach through the abdominal wall for purposes of nutrition and medication administration) received appropriate treatment and services for two of five residents with tube feeding in a sample of 15 residents (1, 3). Resident 1 did not have an abdominal binder in place at all times as ordered. Resident 3's feeding formula was not administered as ordered. This deficient practice had the potential to result in complications such as dislodgment of the GT and unwanted weight gain. Findings: 1. A review of the clinical record revealed Resident 1 was readmitted to the facility on 3/6/12, with diagnoses that included recent history of pneumonia, history of stroke with dysphagia (difficulty swallowing) and GT. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/7/12, indicated the resident was severely cognitively impaired, was incontinent of bowel and bladder	F 322	DON and treatment nurse immediately reassessed Resident # 1 and abdominal binder was applied to resident 05/17/12 Resident #3 feeding formula was reduced from 60ml/hour to 55ml/hour as Physician order. The order rate of 55ml/hour was transcribed in MAR per order. 05/18/12 DON called attention of treatment nurse and license nurse concern regarding MD order of abdominal binding that resident #1 was not wearing it. It was stressed out to them the vital importance of the abdominal binder for the resident in order to prevent pulling out of the GT. Furthermore, it was emphasized that MD order for resident #3 reduction of tube feeding formula should be carried out as order. DON and DSD made round to find out if any of resident is affected as that of resident #1 and #3 for further intervention. DON and QA consultant rein-serviced license nursed on the strict compliance and implementation of MD order. It includes but not limited to order for abdominal binder, treatment and diet such as rate of ml/hour etc. It is important that such order should be carried out accordingly as specified in MD order. It should be part of responsibility to check and ensure that the application and implementation of MD order is in place at all times. All needed information or data should be reflected in resident medical record in all appropriate area such as MAR, treatment sheet and the like.	05/22/12

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F 322	Continued From page 7 functions and was totally dependent on staff for all of her activities of daily living (ADLs). A physician's order dated 1/26/12, indicated to provide feeding with Glucerna 1.2 Cal at 60 milliliters per hour (ml/hr) for 20 hours to provide 1200 ml/1400 calories per day. The order also stated to apply an abdominal binder (bandage or elasticized wrap applied around the lower part of the torso to support the abdomen) at all times to prevent resident from pulling out the GT. A care plan dated 1/26/12, developed for the resident's problem of episodes of trying to pull out the GT, stipulated to provide the abdominal binder as ordered. On 5/17/12, at 12 p.m., during an observation, the resident did not have an abdominal binder in place. By 3:10 p.m., the same day, the resident was not wearing an abdominal binder. At 3:12 p.m., during an interview, certified nursing assistant 2 (CNA 2) indicated she was unaware of the order for a binder. At 3:15 p.m., Licensed Nurse 1 was unable to locate an abdominal binder during a search of the resident's bedside stand and closet. She was then able to locate the binder in the laundry and stated the binder had been removed during the resident's morning care, in order to have it washed. Licensed Nurse 1 further indicated a replacement binder should have been provided in order to prevent the possibility of the resident pulling out the GT. 2. On 5/15/12, at 2:30 p.m., during the initial tour of the facility, Resident 3 was observed lying in bed with an enteral feeding pump at the bedside, delivering a feeding formula at a rate of 85 ml/hr through the resident's GT.	F 322	DON and DSD will monitor during daily round and license nurses Q shift while passing medication or doing treatment. And QA consultant twice a month during consultation visit by checking resident with special device order and on tube feeding to make sure that MD orders are carried out. Medical Record Designee will monitor during weekly audit to ensure compliance. QA will be done monthly to check the effectiveness of system.	

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F 322	Continued From page 8 A review of the clinical record revealed the resident was readmitted to the facility on 9/15/11, with diagnoses that included history of stroke with dysphagia, GT insertion and dementia. The MDS assessment dated 3/21/12, indicated the resident was moderately impaired in her cognitive abilities (decisions poor; cues, supervision required) and required total assistance with all of her ADLs. A review of the Weight Log form indicated the resident's ideal body weight range was 104-127 pounds (lbs). The resident had an increase in weight from 133 lbs on 9/15/11 (admission) to 140 lb. on 4/2/12. By 5/2/12, the resident's weight was 148 lbs. A review of the registered dietitian (RD) Nutritional Progress Notes from September 2011 to May 2012, revealed the tube feeding rate was gradually decreased in conjunction with the resident's weight gain. The most current order was dated 5/4/12, and indicated to decrease Glucerna 1.0 Cal feeding rate from 60 ml/hr to 55 ml/hr for 20 hours to provide 1100 ml/1100 calories per day. A care plan developed for the resident's GT feeding, revised on 3/2012, stipulated in the approaches to provide the GT feeding as ordered. According to the medication administration record (MAR) from 5/4/12 to 5/16/12, the nurses documented the administration of the feeding formula at a rate of 60 ml/hr instead of the ordered rate of 55 ml/hr. In addition, the resident	F 322		

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F 322	Continued From page 9 was observed on 5/15/12, at 2:30 p.m., receiving the feeding formula at a rate of 85 ml/hr and not the ordered rate of 55 ml/hr. During another observation on 5/17/12, at 8:35 a.m., the resident's tube feeding was observed running at 60 ml per hour, and the bottle label also indicated a rate of 60 ml per hour. At 3 p.m. the same day, the pump was observed infusing at a rate of 60 ml per hour. On 5/18/12, at 12:15 p.m., during an interview, Licensed Nurse 1 explained the order dated 5/4/12, to decrease the rate from 60 ml/hr to 55 ml/hr was not transcribed to the MAR. According to the facility's policy on Tube Feeding revised 2/2011, the objective was to ensure each resident receive the proper nutrition and hydration, and that enteral feeding will run based on resident needs and physician's orders.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an environment free from accidental hazards by not securing the television	F 323	Maintenance Supervisor immediately strap television sets on top of the build-in closet and night stand to secure them in Room #1,#5,#7,#9,#10,#12, #17,#26,#28,#29,#30 and #31. Residents' belonging were properly store with resident's approval by social service designee. 05/16 /12 Administrator and Maintenance Supervisor made round in the interior and exterior part of the facility to find out if any other fixture requiring strap or personal belonging of the resident not properly store for immediate intervention.	

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F 323	Continued From page 10 sets on top of the built-in closets and nightstands in the residents' rooms and by having residents' belongings not properly stored. This deficient practice had the potential to result in injury in case of earthquake or accident fall of the television sets and the clutter posed a fire hazard. Findings: On 5/16/12, from 2:05 p.m. through 2:25 p.m., during the environmental inspection, the residents' rooms were inspected with the presence of the maintenance supervisor. Television sets on top of the built-in closets and on top of night stands were observed not secured in Rooms 1, 5, 7, 9, 10, 12, 17, 26, 28, 29, 30, and 31. It was also noted that the residents' rooms were cluttered with multiple residents' personal items were stored piled up on tables and on top of the closets. At 2:25 p.m., during an interview, the maintenance supervisor stated the television sets should be secured and the facility would act on it right away. At 2:30 p.m., during an interview, the administrator stated the facility had to figure out a way to properly store the residents' personal belongings.	F 323	Administrator in-serviced maintenance supervisor to be consistent in checking fixture required strapping for immediate application while social service designee to ensure resident belongings/items is properly stored. Furthermore, resident and resident representative will be met to discuss the value of personal belonging to be properly stored. Those extra belonging which are not being used are to be kept in their home. Administrator, Maintenance Supervisor and Social Service Designee will monitor during their daily rounds by checking the fixture such as TV and by checking resident room for any personal belonging/items that are not properly store. QA will be done monthly to check the effectiveness of system.	05/21/12
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328	DON immediately assessed the resident #14 and called his attending physician. Physician previous order of Oxygen 3-4 L/min via nasal cannula PRN was discontinued and was changed to oxygen 4 L/min via nasal cannula for SOB. 05/17/12	

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F 328	Continued From page 11 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper respiratory care for one of 15 sample residents (14). Resident 14 had been receiving continuous oxygen since readmission when the order was to provide oxygen as needed for shortness of breath. This deficient practice had the potential to result in unnecessary oxygen administration. Findings: A review of the clinical record revealed Resident 14 was admitted to the facility on 6/25/03, and readmitted on 4/7/12, with diagnoses that included chronic obstructive pulmonary disease (COPD) exacerbation, pneumonia, chronic respiratory failure and emphysema (a long-term progressive disease of the lungs that causes shortness of breath). According to the significant change in status Minimum Data Set (MDS - standardized assessment and care planning tool) dated 4/19/12, the resident was able to make his needs known, did not walk, independent in eating and required extensive assistant in the rest of the activities of daily living (ADLs). A physician's order dated 4/7/12, for oxygen at	F 328	License Nurses concerned were reoriented by the DON on the comprehensive assessment of resident, proper notification of assessment to physician, carrying out physician order, including but not limited to order for oxygen. DON and DSD made round to find out if any resident with the MD order of oxygen is affected by the same problem of that of resident#14. DON and RN consultant rein-service license nurses on the consistency of following and carrying out MD order. It includes but not limited to resident with oxygen order. It was emphasized to them the vital necessity of ensuring that MD order is carried out and applied accurately. DON and DSD will monitor during their during round while license nurse will monitor Q shift during medication pass or treatment while QA consultant twice a month during consultation visit by assessing resident to make sure that accuracy of MD order is properly carried out and implemented. QA will be done monthly to check the effectiveness of system.	

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F 328	Continued From page 12 four liters per minute (L/min) via nasal cannula as needed (PRN) for shortness of breath. During multiple observations from 5/15/12 through 5/17/12, the resident was receiving 3 to 4 L/min of oxygen via nasal cannula while in bed. Further record review revealed no documentation the resident had episodes of shortness of breath requiring continued oxygen and that the physician was informed the resident needed oxygen at all times and not just as needed. On 5/17/12, at 12:30 p.m., during an interview, the director of nursing (DON) stated the resident was dependent on oxygen. The DON stated the resident needed continuous oxygen or he would experience shortness of breath. After reviewing with the DON the current physician's order for the use oxygen only on as needed basis, the DON stated she will call the physician for update and correction of the order.	F 328		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received food prepared in a form to meet individual needs for one of 15 sample residents (10) and three randomly selected residents (16, 17, 18). During a dining observation, Residents 10, 16, 17, and 18, who all had orders for pureed	F 365	DON and Dietary Supervisor reassessed resident #10, #16, #17 and #18 respectively of their diet order and the food served to them. Pureed diet is now being process and prepared in accordance of pureed diet process to meet these residents needs. Administrator called the attention of the Dietary Supervisor to be vigilant regarding diet preparation for each resident as RD recommendation and MD order. Furthermore that those who have special diet order like pureed food consistency and texture should be in accordance to resident needs and as MD order. 05/17/12	

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F 365	Continued From page 13 diet, were served cubed bread instead of pureed. This deficient practice had the potential to result in the residents choking. Findings: On 5/16/12, from 12:15 p.m. to 12:45 p.m., a dining observation in the restorative nursing assistant (RNA) program dining area, Residents 10, 16, 17 and 18, were observed having lunch and the following was noted: 1. Resident 10's lunch consisted of pureed beef, pureed mixed vegetables and mashed potatoes. There was also a bowl containing cubes of cut-up bread. There was no liquid in the bowl. The RNA supervising the resident indicated the bread was usually soaked in milk but the resident preferred the bread be served dry. A review of the clinical record disclosed the resident was admitted to the facility on 3/05/12, with diagnoses that included dementia and high blood pressure. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 3/17/12, indicated the resident had periods of confusion and required minimal to extensive assistance with most of her activities of daily living (ADLs). A physician's order dated 3/14/12, indicated a pureed diet. At 12:40 p.m. during an interview, the dietary service supervisor (DSS) stated pureed bread consisted of cubed bread with added milk. The DSS also stated she was unaware milk was not added to the resident's bread and nursing staff	F 365	Administrator had conversation with RD consultant to make sure that during consultation visit emphasis should be base on diet consistency with MD order especially for resident who have modified diet such as mechanical soft, purred diet and the like. Administrator further had talk to DON to ensure that proper notification of dietary supervisor of the diet of all resident admitted and in house as well as any changed made in diet order of the resident. DON and DSD checked other resident's food tray to find out if any of the residents is affected by the same problem of resident #10, #16, #17 and #18 for immediate intervention. Administrator and RD consultant in-serviced Dietary Supervisor regarding strict compliance and implementation of the policy on therapeutic diet. It includes but not limited to the must of complying in the preparation of modified diet like pureed food in the consistency and texture desired to meet resident dietary needs and as MD order. It was further emphasized to her that her present during preparation and food serving is required. A timely and appropriate communication with nursing department is needed in order to be updated with resident diet order by attending physician. DON in-serviced license nurses to be consistent in notifying dietary department / supervisor for all MD orders for resident diet at all times. It is order for admission or any changes in diet order if applicable.	05/23/12 05/22/12

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F 365	Continued From page 14 had not informed her. The DSS stated she conducted meal observations, but had not noticed the resident's bread was served without milk. 2. Resident 16, who was being assisted with eating by a staff member, had pureed beef, pureed vegetable, and mashed potatoes. There was also a bowl of cubed bread, with milk at the bottom of the bowl. The bread on top was dry. A review of the clinical record revealed the resident was readmitted to the facility on 6/05/11, with diagnoses which included Parkinson's Disease (a progressive disorder of the nervous system that can affect the muscles used for chewing and swallowing) and dementia. The MDS assessment dated 4/22/12, indicated cognitive impairment and the resident required extensive staff assistance with all of his ADLs. A physician's order dated 7/11/11, indicate fortified puree no concentrated sweets diet. 3. Resident 17 who was also being assisted by a staff member, had a plate which contained pureed food, and a bowl of cubed bread, with milk in the bottom of the bowl. A review the clinical record revealed the resident was admitted to the facility on 4/23/12, with diagnoses which included stroke with dysphagia (difficulty swallowing), as well as multiple joint contractures. The MDS assessment dated 5/5/12 indicated the resident's cognitive skills were severely impaired and required total staff assistance with all of his ADLs. A physician's order dated 4/23/12, indicated	F 365	Dietary Supervisor, DSD and License Nurse will monitor during their during resident meal time by checking resident's food consistency per physician order while RD consultant Q month during consultation visit by checking food preparation process for accuracy of food consistency especially for resident who have modified diet such as mechanical soft, purred diet and the like and to make sure that diet consistency accuracy of MD order is properly carried out and implemented QA will be done monthly to check the effectiveness of system.	

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F 365	Continued From page 15 pureed fortified diet. 4. Resident 18 had a pureed lunch which included a bowl of cubed bread with milk noted in the bottom of the bowl and dried bread on top. A review of Resident 18's clinical record indicated the resident was readmitted to the facility on 10/11/08, with diagnoses which included history of stroke with left sided weakness and dysphagia. The MDS dated 3/26/12, indicated the resident was severely cognitively impaired and required extensive assistance with his ADLs. A physician's order dated 1/20/09, indicated pureed diet with honey- thickened liquids. On 5/16/12, at 2:45 p.m., during a telephone interview with the registered dietitian (RD) consultant, she explained two acceptable methods for preparing pureed bread included pouring milk over bread which had been finely crumbled, or to puree bread slices and milk together in a blender. According to the facility policy titled "Therapeutic Diet" revised 09/2011, pureed food is modified in consistency and texture by measuring the desired number of servings into the processor container, add liquid or thickener to obtain desired consistency, and to process food to desired consistency. The policy further indicated the Dietary Supervisor will establish a tray identification system to insure each resident received his/her diet as per physician's order.	F 365		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 16 (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 ensure food was stored, distributed and served under sanitary conditions by having no labels identifying foods stored in the kitchen walk-in refrigerator and having rust on the cooling system fan-guard. There was a leaky hot water faucet above the kitchen two compartment sink and dried food in the can opener. This deficient practice had the potential for food contamination and foodborne illness. Findings: On 5/15/12, at 1:00 p.m., during the initial inspection of the kitchen in the presence of the dietary service supervisor (DSS), the following was observed: 1. There were no labels identifying food stored inside the kitchen reach-in refrigerator: a. Food trays containing different kind of food items inside individual bowls and glasses of milk and juices of various colors. The DSS identified the food items inside individual bowls as blackberry yogurt, custard and	F 371	Dietary Supervisor immediately separated food items in the food tray such as bowls / glasses and juices of various colors. The tray of slices bread was labeled and dated. The tray of dessert with dessert like yogurt and custard was labeled and dated as well. Glasses of regular milk were separated in one tray and labeled and dated. Especial type of milk glasses like low fat, non-fat and mocha mix were individually labeled and dated. Same was done to the glassed of cranberry, orange and prune juice. 05/15/12 Maintenance Supervisor cleaned rust in walk-in refrigerator cooling system fan –guard and repaired leaky hot water faucet above the kitchen two compartments. While dietary aids cleaned dried food residue in and around the large kitchen can opener. 05/15/12 Administrator immediately called attention dietary supervisor to be vigilant in complying with policy and procedure on food storage, labeling, dating and sanitation. Administrator and QA consultant went to check kitchen condition to find out if there is any other food / juice not properly label and dated and any area requiring cleaning/repairing for immediate intervention. Administrator in-serviced dietary supervisor consistency in performing her duties and responsibilities as head of dietary department. It includes but not limited to ensuring that all policy and procedure on food storage indicating foods and food drinks stored in refrigerator are labeled and dated.	

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F 371	Continued From page 17 slices of bread. b. Glasses of drinks and juice which the DSS identified as regular milk, low fat milk, mocha mix, cranberry, orange and prune juice. 2. There was a significant amount of rust on the walk-in refrigerator cooling system fan-guard. 3. There was a leaky hot water faucet above the kitchen two compartment sink. 4. There was dried food residue in and around the large kitchen can opener. A review of the facility's policy and procedure on Food Storage indicated foods and food drinks stored in the refrigerators need to be labeled and dated.	F 371	Furthermore cleanliness, sanitation should be observed at all times. Equipment and devices used in the kitchen should be all in good operating condition, repair or replacement should be done if applicable. Administrator and Dietary Supervisor or designee will monitor during daily round while RD consultant during the monthly visit same as QA consultant twice a month during their consultation visit by visually checking kitchen for sanitation, equipment condition, refrigerator for food labeling/dating and the like. QA will be done monthly to check the effectiveness of system.	05/21/12
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	F 425	DON and license nurse assessed resident #7 to find out if there was any adverse side effect of multivitamin suspension when license nurse failed to shake well the bottle before administering the medication. None was noted. MD and resident representative of resident #7 was notified by the license nurse 05/16/12. Resident#13 was like wise assessed by the same. No adverse side effect was noted. MD and resident representative of resident #13 was notified by license nurse 05/17/12. Resident #19 was assessed by DON and license nurse involved for any side effect secondary to license nurse failed to wait 3-5 minutes before the second eye drops were instilled. None was noted. 05/16/12	

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F 371	Continued From page 17 slices of bread. b. Glasses of drinks and juice which the DSS identified as regular milk, low fat milk, mocha mix, cranberry, orange and prune juice. 2. There was a significant amount of rust on the walk-in refrigerator cooling system fan-guard. 3. There was a leaky hot water faucet above the kitchen two compartment sink. 4. There was dried food residue in and around the large kitchen can opener. A review of the facility's policy and procedure on Food Storage indicated foods and food drinks stored in the refrigerators need to be labeled and dated.	F 371	Furthermore cleanliness, sanitation should be observed at all times. Equipment and devices used in the kitchen should be all in good operating condition, repair or replacement should be done if applicable. Administrator and Dietary Supervisor or designee will monitor during daily round while RD consultant during the monthly visit same as QA consultant twice a month during their consultation visit by visually checking kitchen for sanitation, equipment condition, refrigerator for food labeling/dating and the like. QA will be done monthly to check the effectiveness of system.	
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	F 425	DON and license nurse assessed resident #7 to find out if there was any adverse side effect of multivitamin suspension when license nurse failed to shake well the bottle before administering the medication. None was noted. Attending physician and resident representative of resident #7 was notified by the license nurse 05/16/12. Resident#13 was like wise assessed by the same. No adverse side effect was noted. Attending Physician and resident representative of resident #13 was notified by license nurse 05/17/12.	

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F 425	Continued From page 18 services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide safe pharmaceutical services, including procedures that assure the accurate dispensing, administering and transcribing all medications for two of 15 sample residents (7, 13) and one randomly selected resident (19). Resident 7 received Multivitamin liquid suspension without shaking the bottle as directed by the manufacturer. Resident 13 received acetaminophen (Tylenol) but its administration was documented before it was actually given. Resident 19 had an order for two different eye drops for glaucoma. The licensed nurse instilled the second eye drop without waiting three to five minutes after instilling the first eye drop for optimal eye drop absorption. This failure had the potential for medication error and ineffective drug therapy. Findings: 1. On 5/16/12, at 8:45 a.m., an observation of Medication Nurse 1 administering the morning medication to Resident 7 was conducted. Medication Nurse 1 prepared a total of six medications including Multivitamin liquid suspension. Medication Nurse 1 failed to shake well the bottle as directed on the manufacturer's label of the bottle before administering the medication via a gastrostomy tube (GT).	F 425	Resident #19 was assessed by DON and license nurse involved for any side effect secondary to license nurse failed to wait 3-5 minutes before the second eye drops were instilled. None was noted. Attending Physician and resident representative of resident #19 was notified by license nurse. 05/16/12 DON and RN consultant assessed and reviewed other resident with MD order of multivitamin liquid suspension and observe license nurse while passing the medication to find out if any of them that not comply with direction per manufacture label and / or MD order or if anyone signed MAR before administration of medication for immediate intervention. None was noted. DON, RN consultant and Pharmacy consultant will in-service license nurse on policy and procedure on medication administration. It includes but not limited to complying in carry out MD order and /or manufacture guideline such as shaking the bottle of multivitamin liquid suspension before its administration, waiting 3-5 minutes before the second eye drops instilled for optimal absorption and ensure medication was administered before signing / documenting in MAR to make sure medication is actually given and the like.	05/22/12

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F 425	Continued From page 19 At 9:22 a.m., when asked if the Multivitamin liquid suspension bottle needed to be shaken well before use, Medication Nurse 1 stated the medication administration record (MAR) did not provide an instruction to shake the bottle well. A review of the clinical record revealed the resident was admitted to the facility on 10/3/11, with diagnoses that included dysphagia (difficulty swallowing), status post GT placement and anemia. The quarterly Minimum Data Set (MDS - standardized assessment and care planning tool) dated 4/13/12, indicated the resident was cognitive impaired in daily decision- making and was totally dependent on staff for activities of daily living (ADLs). A physician's order dated 10/3/11, indicated Multivitamin 5 cubic centimeters (cc) via GT daily as supplement. The manufacturer's label on the bottle of Multivitamin liquid suspension, instructed the user to shake well before use. 2. On 5/17/12, at 9:05 a.m., while observing Medication Nurse 2 administer morning medications to a resident, Licensed Vocation Nurse 1 (LVN 1) approached Medication Nurse 2 and stated she would be giving pain medication to Resident 13 for pain on the buttocks area. After verifying on the MAR a physician's order for acetaminophen (generic name for Tylenol) for pain, LVN 1 proceeded to document in the MAR the administration of the medication timed at 9:06	F 425	DON or designee will monitor daily during medication pass while RN consultant twice a month during consultant visit and pharmacy consultant monthly during consultant visit by following license nurse while passing medication to ensure compliance. QA will be done monthly to check the effectiveness of system.	

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F 425	Continued From page 20 a.m. Medication Nurse 2 proceeded to look for the Tylenol in the medication cart but there was none. Medication Nurse 2 gave LVN 1 a set of keys for LVN 1 to get a new bottle from the supply room. At 9:15 a.m., during an observation, LVN 1 took one tablet of Tylenol from the new bottle, stored the new bottle inside the medication cart and left the area. A review of the clinical record revealed the resident was admitted to the facility on 6/30/05, and re-admitted on 4/25/12, with diagnoses that included diabetes mellitus and degenerative arthritis. The quarterly MDS assessment dated 5/1/12, indicated the resident was able to make her needs known, did not walk and required extensive assistance in bed mobility and personal hygiene. A physician's order dated 4/25/12, indicated acetaminophen 325 milligram (mg) by mouth every four hours as needed for pain. On 5/17/12, at 9:45 a.m., during an interview, LVN 1 reported she administered the pain medication to the resident at 9:15 a.m., instead of 9:06 a.m. LVN 1 stated she should have signed the MAR after giving the medication and not before. According to the facility's policy and procedure on Medication Administration, revised on 11/2008, medications must be immediately charted following the administration by the person administering the drugs.	F 425		

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	056458	A. BUILDING _____ B. WING _____	05/18/2012

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F 425	Continued From page 21 3. On 5/16/12, at 8:10 a.m., during the medication pass observation for Resident 19, Medication Nurse 3 administered one drop of Timolol 0.5 percent (%) to the resident's left and the right eyes. After one and a half minutes, Medication Nurse 3 applied Azopt one drop to the left eye. A review of the clinical record disclosed the resident was admitted to the facility on 10/25/11, with diagnoses that included psychosis and left eye blindness. A physician's orders dated 10/25/11, indicated Timolol 0.5 percent (%), one drop to both eyes twice daily for glaucoma (increased pressure in the eye). Another order dated 4/23/12, indicated Azopt ophthalmic one drop to the left eye twice daily for glaucoma. A review of the facility's policy and procedure on Eyedrop Administration, revised 6/2009, stipulated to wait three to five minutes between multiple eye drops. On 5/17/12, at 2 p.m. during an interview, Medication Nurse 1 stated she should have waited three to five minutes to administer the Azopt, after administration of the Timolol.	F 425		
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.	F 441	CNA 1 and 2 were immediately confronted by the DSD. They were re-oriented and rein-serviced the policy and procedure of infection control. It includes but not limited to maintain a safe, sanitary and comfortable environment that prevent transmission of disease and infection. It can easily be demonstrated by not carrying a clean item like box of glove in one hand and not holding dirty item in other hand.	

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F 441	Continued From page 22 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, sanitary environment to prevent development and transmission of infection. Certified nursing assistant 1 (CNA 1) was observed carrying a new box of disposable	F 441	Furthermore, any clean item should not be place on the top of any resident fixture like over bed table and be transported and put on the top of clean item like clean linen cart or clean incontinent briefs. 05/16/12 DON and DSD made round to find out if there is any other CNA had been doing what CNA 1 and 2 had done for proper redirection. DSD rein-serviced CNAs on infection control policy and procedure. It includes but not limited to providing safe, sanitary environment to prevent development and transmission of disease and infection It was emphasized to them that clean item can not be mixed with dirty item. If dirty item is being removed from its origin like resident room, shower room or closet, such should be disposed/discarded, washed CNA hand then touch the clean item. Any item to be use by any resident should not be brought from one resident room to other room since it could be a good source of infection contamination and the like. DON and DSD or designee will monitor during their daily round while license nurse Q shift during medication pass QA consultant twice a month or more during consultation visit by checking CNA while providing resident care for compliance. QA will be done monthly to check the effectiveness of system.	05/22/12

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F 441	Continued From page 23 gloves in the same hand with a bag containing a soiled incontinent brief. This deficient practice had the potential to result in contamination to other residents. Findings: On 5/16/12, at 8:15 a.m., CNA 1 was observed in Nursing Station 2 hallway, holding in one hand an unopened box of disposable gloves and a plastic bag which contained a soiled incontinent brief and pushing a shower chair with the other hand. CNA 1 disposed of the plastic bag in the dirty utility room, walked back up the hallway, entered Room 26, then immediately returned to the hallway without the box of gloves. At 1:50 p.m. the same day, during an interview, CNA 1 stated she had placed the box of gloves on the over the bed table of one of the residents in Room 26 so that she and her partner could access the gloves. When asked the current location of the gloves, CNA 2 pointed to the side of a small linen cart in the hallway. The box of gloves had been placed on top of several clean incontinent briefs. CNA 1 then stated she should not have carried clean and soiled items at the same time and the gloves should not have been placed on the clean linen cart, due to contamination risk.	F 441		
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456	Maintenance Supervisor immediately ordered two laundry dryer lint filters which arrived on 05/18 /12 and installed immediately by the same.	

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F 456	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain essential mechanical equipment in a safe operating condition by having one of two laundry dryers with a torn and broken lint filter. Accumulation of lint may pose a fire risk. Findings: On 5/15/12, at 3:45 p.m., during the tour of the laundry room in the presence of the maintenance supervisor, Dryer # 2 had a torn and broken lint filter. On 5/15/12, at 3:50 p.m., during an interview, a laundry aide could not explain the reason the broken lint filter was not repaired or replaced.	F 456	There was no other dryer in the facility but these two with newly replaced laundry dryer lint filter. Administrator in-serviced to be consistent in checking the dryer for any broken filter for immediate replacement. Maintenance Supervisor in-serviced laundry personal to clean the laundry dryer lint filter as scheduled and report for any damaged that requires repair / replacement. Administrator and Maintenance Supervisor or designee will monitor during their daily round by checking all mechanical equipments including but not limited to laundry dryer lint filter to ensure that all essential mechanical equipments are in safe and good operating condition. QA will be done monthly to check the effectiveness of system.	05/21/12