Initial POC delivered 01/24/12 unacceptable 3/2/12 accepted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. BUILDING _____ B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND PARK CONVALESCENT HOSPIT	2312 WEST 8TH STREET LOS ANGELES, CA 90057

(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 reflect the findings of the Department of Public Health during a recertification survey. Representing the Department of Public Health: [redacted] Total Resident Population: 146 Total Resident Sample: 24 Highest Scope & Severity - E	F 000	**PLEASE ACCEPT OUR PLAN OF CORRECTIONS AS OUR CREDIBLE ALLEGATIONS FOR CONTINUED COMPLIANCE.** *** All the following deficiencies will be elevated and discussed in the next Quality Assurance Meeting for follow up and re-assessments to prevent re-occurrence of such deficiencies.**	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to ensure one of 24 sample residents (12) was kept warm during a bed bath. Resident 12 complained of being cold the entire time certified nursing assistant 2 (CNA 2) bathed the resident. CNA 2 put a towel over the resident's chest area after bathing the upper body, however, the resident	F 246	**F 246** **We will continue and abide with the policy and practice of this facility that all Resident's should be comfortable and warm, with reasonable accommodations of individual needs, including but not limited to bedside care, as well as in the giving of bed bath/showers. He/She should be comfortable and warm by using extra towels or blankets appropriately to cover all uncovered portion of his/her body to assure that Residents are comfortable and warm. C.N.A.'s should likewise make sure that the room of the Resident or shower room is warm and comfortable or else to refer to the maintenance supervisor for adjustment of the thermostat control. C.N.A.'s should likewise inform and explain the procedure to the Resident prior to the start of the said bed bath/showers.** **Bed baths and or Showers are given individually twice a week on the 7-3 shift except Sundays but should be given any day or shift including Sundays if needed, by the C.N.A.'s.** **The following Staff were in serviced that it is the responsibility of all C.N.A.'s to**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	3-2-12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 246	Continued From page 1 arms and shoulders were left exposed. Failure to cover Resident 12's entire upper body left the resident cold, uncomfortable and as if her feelings were not important. Findings: On January 19, 2012, at 9 a.m., Resident 12 was observed during her morning bed bath. From the time CNA 2 started giving the bath until the completion of the bath, Resident 12 complained of being cold. After the CNA finished bathing the resident's face, neck, chest and arms, he covered the resident's chest and abdomen with a towel. Resident 12's arms and shoulders were left exposed to the air as the resident continued to complain of being cold. A review of the medical record indicated Resident 12 was admitted to the facility on March 26, 2011, with diagnoses including gastrostomy tube feeding and rheumatoid arthritis. The Minimum Data Set assessment dated December 22, 2011, indicated Resident 12 required extensive assistance with bathing and dressing. A review of the Nurses Weekly Progress Notes dated January 22, 2012, indicated Resident 12 had clear speech, always made herself understood and was always understood by others. On January 24, 2012, at 12:25 p.m., CNA 2 stated he should have covered up the Resident 12's arm and shoulders to make sure the resident stayed warm.	F 246	**F 246** **provide comfortable and warm bed bath at all times as well as coverage with extra towels and or blankets of all exposed body parts at all times, except the face and the part being cleansed during bed bath to any Resident, especially those who require Physical assistance and or supervision in their activities of daily living.** **The Licensed Nurse will make sure that this practice and or policy will be implemented at all times and can be accomplished by their direct observation of all C.N.A.'s while giving the Residents medications/treatments on the 7:00 AM to 3:00 PM shift, everyday, and or at the initial rounds of all Residents after breakfast, at 8:30 AM and before lunch at 11 AM, when checking all Resident's that were scheduled on that particular day had received their showers or bed bath.** **The D.S.D. will assure continued compliance by in servicing all C.N.A.'s, and Licensed Nurse's on the proper technique in giving showers or bed bath including outside factors like extra blankets/towels and room temperature. Also, to check/follow up during daily rounds on Mondays through Fridays and at least twice a day.** **In services of all C.N.A's and Licensed Nurse's was given by the D.S.D in providing bed bath or showers, properly to all Residents. Resident 12's C.N.A. on January 19, 2012, that was noted by the State Survey Team was counseled by the DSD upon receipt of the above deficiency with a return demonstration on how to give proper bed bath or showers and was corrected and showed by the DSD of any incorrect procedure, (s).**	

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F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based observation and interview, the facility failed to provide a safe, clean, comfortable and homelike environment. This deficient practice had a potential to make the residents feel sad about environment. Findings: On January 18, 2012, at 12:30 p.m., during the initial tour of the facility the following were observed: 1. There were brown water stains on the ceiling in the entrance of room 26. 2. There were brown stains noted on the lamp shades in Rooms 26B, 28A, 34A and 34B. 3. The refrigerator in 19B had an accumulation of dried food and debris. There was no thermometers for the refrigerators in 25A, 31A, 35A, 35 B and there was a broken thermometer in the refrigerator 29B. This deficient practice had a potential to make the residents feel sad about environment.	F 252	~~F 252~~ **In services to the rest of the Nursing Staff was given by the DSD with some return demonstrations and completed on - - -** **It is the practice and policy of this facility to provide a safe, clean, comfortable, and homelike environment as well as maintaining furniture's/fixture's to be in good repair, to all Resident's rooms and surroundings, including but not limited to cleaning, repair and replacement of the following that was noted by the Survey Team: A. Brown water stains on the ceiling of Room 26 was cleansed and repainted by the Maintenance Supervisor.** **B. Stains on lamp shade covers in room's 26-B, 28-A, 34-A and 34-B were all replaced.** **C. Dried food and debris in Room 19-B's refrigerator. Were cleansed immediately. Broken or missing refrigerator thermometers in rooms 25-A, 31-A, 35-A & B, and room 29-B were replaced.** **The Housekeeping/Janitorial Staff were in serviced that it is their responsibility to cleanse immediately any stains/debris or report to their Supervisor any stains that is not readily removed with regular cleaning solution to any walls, ceilings, furniture's/fixtures or any part of the building to the Maintenance Supervisor for cleaning/repainting, or replacement. Likewise it is their responsibility also, to log/write any items in the maintenance log book at stations I & II anything that is broken or missing like refrigerator thermometers or furniture's/fixtures so that it will be replaced ASAP by the**	1/27/12
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 3 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to assess one of 24 sample residents (6). Resident 6 who had a congested cough and a black toenail on the 3rd toe of the left foot. The deficient practice had a potential for Resident 6 to develop breathing problems and infection to the left third toe. Findings On January 19, 2012, at 9:50 a.m., during the treatment observation for Resident 6, the	F 279	**F 252** **Maintenance Supervisor. The above chores will be accomplished on a daily basis, by the Housekeeping/Janitorial Staff from Mondays to Fridays between the hours of 5:30 AM to 6:30 PM, & on Saturdays to Sundays from 5:00 AM to 9:00 PM respectively.** **The Maintenance and Janitorial Supervisors will make sure that the above practice and policy will be implemented by checking the Supervisors Maintenance log on Stations I & II on a daily basis, from Mondays to Fridays. The Administrator/Designee will monitor for continued compliance by double checking the Supervisors Maintenance Log and a weekly rounds of the Resident's rooms and the physical plant/building one's a week or randomly between Mondays to Fridays.** **In service and counseling of the above Staff in regards to the above issues was done by Administrator/Designee and completed on -** 2/24/12 **F 279** **The facility will continue to provide comprehensive care plan for each Resident that includes measurable objectives and timetables to meet their medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.** **In order to prevent re-occurrence of the above deficiencies, to any Residents, All Charge/Treatment Nurse's were reminded that it is their responsibility to evaluate/assess any Resident who has a**	

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F 279	Continued From page 4 resident's left foot third toe, toenail was black and the treatment nurse did not provide any treatment at that time. The resident was heard coughing with a rattling sound in his chest. The resident's coughing was heard various times during first two days of the survey. A review of the clinical record on January 19, 2012, at 11:30 a.m., indicated Resident 6 was readmitted to the facility on December 30, 2011 with diagnoses that included dementia and possible aspiration pneumonia. The resident's Minimum Data Set (MDS - care and screening tool) dated January 13, 2012, indicated the resident's cognition was moderately impaired, and his decision-making were poor and dependent on staff for his care needs. A review of the Licensed Nurses progress notes dated from January 18, 2012 to January 21, 2012, indicated there was no documentation that there had been a continuous assessment of the resident's coughing and his third left toe. There was no documentation that the physician had been notified of the resident's black toenail. When interviewed on January 24, 2012, at 10:20 a.m., Registered Nurse 1 (RN 1) stated during rounds they check the resident for coughing and shortness of breath. However, he could not provide any documentation A review of the Licensed Nurses progress notes dated January 21, 2012, at 8:30 a.m., two days after the initial observation the documentation indicated the resident was awake with episodes of coughing and was placed on three liters of	F 279	**F279** **change of condition with the following examples but not limited to, cough and Congestion/respiratory problems, black/discolored toe. Like in the case of Resident 6, any cough that is noted should have their lungs evaluated through the use of a stethoscope, by auscultating through out the lung fields noting any abnormal lung sounds like wheezing, congestion, etc., by a Licensed Nurse. Nursing measures should be initiated like semi-fowlers position in bed, encourage increasing fluid intake. Give all appropriate PRN medication for any respiratory problems. Vital sign should be taken with a pain rating before calling or referring to the attending Physician. Likewise, a care plan should be initiated before the end of their shift while incorporating any MD's orders. Also, to inform the Resident and or responsible Party of the Resident's current condition including current medication and or treatments. Also with Resident 6, any black toenail or change of condition should be assessed immediately, take the vital signs and refer to the attending MD/Podiatrist and Resident or Responsible Party. Treatment should be initiated immediately after the attending MD/Podiatrist has been notified of the above and given a treatment order. Treatment modalities and or medications should be initiated ASAP or within 4 hours for non-availability medications/treatment by any route.** **The RN Supervisors will make sure that the above measures are implemented but not limited to reports from the previous shift Supervisor, 24-hour endorsement/log book, their rounds daily in all 3 shifts, which is**	

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F 279	Continued From page 5 oxygen by a nasal cannula. The resident was transferred to the acute hospital for fever, shortness of breath and congestion.	F 279	~~F 279~~ **done at the start of their shift, at the middle of their shift and before reporting/endorsing to the on-coming shift. The DON counseled the Licensed Nurse for Resident 6 just after the exit conference With State Surveyor in relation to the above deficiency. He will also monitor for continued compliance by correcting any of the above on his daily rounds, between 9 AM to 5 PM from Mondays to Fridays of all Residents, stand-up meetings/RN Supervisors daily meeting and reading the 24-hour endorsement/log book. In services were given with the rest of the Licensed Nursing Staff by the DON and completed on**	1/27/12
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's nursing staff failed to assess Resident 7 who had a congested cough and to administered the breathing treatment as ordered, to get a medication order renewed for continued use, and to apply prevalon boots to the heels for three of 24 sample residents (7, 11, 12). A physicians order dated December 29, 2011, indicated Calmoseptine cream was to be used on Resident 11 for a scrotal excoriation. The order indicated the medication was to be used for 14 days, or until January 12, 2012. On January 19, 2012, the nursing staff was observed still using the Calmoseptine cream on Resident 11. A physicians order dated December 16, 2011, indicated Resident 12 was to wear prevalon boots (pressure relieving heel protectors) on her bilateral heels for skin management. Multiple observations were made at different times of each day, from January 18 through the 24, 2012, where the resident did not have the boots on	F 309	**F 309** **The facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with comprehensive assessment and plan of care including but not limited to;** **A. Resident's having URI or cough/congestion should be monitored for their vital signs, lung sounds, respirations, color and consistencies of nasal and**	

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F 309	Continued From page 6 either of her heels. Failure to assess the resident respiratory status had a potential for medical complications and failure to apply the boots created a potential for skin breakdown. Findings a. On January 20, 2012, at 9 a.m., during the morning care observation for Resident 7, the resident was heard coughing with a rattling sound in her chest. The resident's coughing was heard various times during first two days of the survey. A review of the clinical record on January 20, 2012 at 9:50 a.m., indicated Resident 7 was readmitted to the facility December 12, 2011, with a diagnoses that included dementia and pneumonia. The resident's MDS dated December 24, 2011, indicated the resident's cognition was moderately impaired, decision-making were poor and dependent from staff for her care needs. A review of the Licensed Nurses progress notes dated from December 29, 2011 to January 20, 2012, indicated there was no documentation that there had been a continuous assessment of the resident's coughing. There was no documentation the physician was notified of the resident's congestion. There was a physician's order dated December 12, 2012, for the nurses to provide a hand held nebulizer treatment every four hours if needed for shortness of breath or congestion.	F 309	**F 309** **or pharyngeal secretions and refer to MD for any abnormality.** **B. All treatments should have a current order, re-order/extension or discontinuation according to the needs of the Resident and or assessment by the Licensed Nurse and ultimately an MD order.** **C. Medicated treatments unless it is a basic A & D ointment has to be applied by a Licensed Nurse.** **D. Prevalon boots has to be clarified or ordered, when to apply and when to take it off. If Resident has a tendency to take off his/her own then it should be evaluated by the Licensed Nurse accordingly and referred to the MD if needed.** **Likewise it should be care planned and as well as reported to the MD and responsible Party if refusing.** **To prevent re-occurrence of the above deficiencies that was noted by the State survey Team;** **It is the responsibility of the Charge/Treatment Nurse to assess or evaluate Resident the lung sounds, give treatments as ordered, be it routine and or PRN and note or report back to MD of the result of such medication and or treatment, request to MD for extension, re-order and or discontinuation of such medications and or treatments. Likewise, all abnormal parameters have to be referred to MD including initial outcomes of such medication and or treatment and also informing the outcome to Resident or Responsible Party.**	

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F 309	Continued From page 7 A review of the Medication Administration Record (MAR) from January 1 to 25, 2012, indicated the resident was not provided with the hand held nebulizing treatment for the congestion that had been ordered by the physician. During an interview on January 23, 2012, at 9:15 a.m., the Director of Nurses stated the licensed nurses should be documenting the resident's condition, assessing the resident's lung sounds and the effectively of the breathing treatment. b1. On January 19, 2012, at 10 a.m., Resident 11 was observed during a bed bath. Upon completion of the bath, the registered nurse supervisor gave CNA 1 Calmoseptine cream, a skin treatment/protectant, to apply to the resident's skin. A review of the medical record indicated Resident 11 was admitted to the facility on December 29, 2011, with diagnoses including cerebrovascular accident with left hemiparesis. A physician's order dated December 29, 2011, indicated Calmoseptine cream was to be used on Resident 11 for a scrotal excoriation. The order indicated the medication was to be used for 14 days, or until January 12, 2012. However, the nursing staff continued to use the medication beyond the prescribed time which was seven days after the treatment order was completed. A resident care plan dated December 29, 2012, addressed Resident 11's skin integrity. The nursing approaches included providing the resident with treatment as ordered.	F 309	**F 309** **It is also the responsibility of the Charge Nurse to remind and supervise the applications of brace, immobilizers and or application of a prevalon boots to a particular Resident including the time of application and or removal, if any. If Resident refuses the application or taking it off or refusing to use it then the Attending Physician will be called and advised what is going on with Resident and follow what is ordered and the said Licensed Nurse will initiate the corresponding Care Plan.** **The RN Supervisor will make sure that the above Nursing service will be implemented through his/her daily rounds, and at least twice on their respective shift.** **The DNS will assure for continued compliance through his daily rounds or at least twice a day on Mondays to Fridays.** **In services and counseling of all the Licensed Staff & C.N.A.'s that was involved with Resident 's 7, 11 &12's care, on the 7-3 & 3-111 shifts, from January 18, 2012 to January 24, 2012 was done by the DON on January 25, 2012 and the rest of the Licensed Staff and C.N.A.'s was completed on** ----------	1/27/12

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F 309	Continued From page 8 A review of the Nurses Weekly Progress Notes dated January 15, 2012, indicated Resident 11 had a scrotal excoriation and the area was being treated with Calmoseptine. On January 25, 2012, at approximately 10 a.m., a review of the resident's medical record, with the director of nursing, failed to produce a physician ' s order for the continued use of the Calmoseptine cream. The director of nursing agreed a physician ' s order should have been renewed for continued use of the Calmoseptine on Resident 11. b2. On January 19, 2012, at approximately 9 a.m., the registered nurse supervisor was observed handing CNA 1 the Calmoseptine cream to apply to Resident 11's excoriated perineal area. CNA 1 took the Calmoseptine cream and spread it inside of the resident's diaper instead of on the skin/excoriated area. According to the literature, a fact and comparison sheet on use of Calmoseptine, the cream and/or ointment should be applied to the affected area and rubbed in gently. Calmoseptine is for external use. On January 24, 2012, at 12:10 p.m., the registered nurse supervisor stated the Calmoseptine cream was given to the CNA for application on Resident 11 because the treatment nurse was busy with another resident. The supervisor agreed he should have applied the medication to the resident himself if the treatment nurse was busy to ensure it was applied correctly. c. On January 18, 19, 20, 23 and 24, 2012,	F 309		

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F 309	Continued From page 9 Resident 12 was observed at several intervals without the prescribed prevalon boots on her bilateral heels. Observations were made daily between 8 a.m. and 4 p.m. where the boots were off of the resident more often than they were on. A review of the medical record indicated Resident 12 was admitted to the facility on March 26, 2011, with diagnoses including gastrostomy tube feeding and rheumatoid arthritis. A physician's order dated December 16, 2011, indicated the prevalon boots were to be applied to Resident 12's heels for skin management. A resident care plan dated December 16, 2011, addressed Resident 12's decline in physical functioning requiring assistance from staff with her activities of daily living. The nursing approaches included providing the resident with pressure reducing devices. On January 20, 2012, at 3:15 p.m., Resident 12 stated the staff does not put the boots on all of the time. The resident stated she would put them on herself but she cannot do it herself. A facility policy and procedure on "Heel Protectors" (no date) indicated the equipment was to prevent skin irritation and pressure sores.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND PARK CONVALESCENT HOSPIT	2312 WEST 8TH STREET LOS ANGELES, CA 90057

(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 312	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to use soap on three of 24 sample residents (7, 11, 12) during their morning bed baths. Certified Nursing Assistant 1 used a cloth with water and vitamin A & D ointment (A&D is a diaper rash ointment and skin protectant) on it during a bed bath for Resident 11. CNA 2 used peri-wash to bathe Resident 12's entire body during a bed bath. CNA 3 used clear water and no soap to bathe Resident 7. Failure to use soap during a bed bath created the potential for infection and skin breakdown. Findings: a. On January 20, 2012, at 9 a.m. Resident 7 was observed during a bed bath. CNA 3 used a wet cloth and no soap to clean the resident during the bed bath. A review of the clinical record on January 20, 2012, at 9:50 a.m., indicated Resident 7 was readmitted to the facility on December 12, 2011, with diagnoses that includes dementia and pneumonia. The resident's Minimum Data Set (MDS) care and screening tool dated December 24, 2011, indicated the resident's cognition was moderately impaired, had poor decision-making and dependent on staff for her care needs. An interview was conducted with the staff developer on January 23, 2012, at 9:15 a.m., he	F 312	**F 312** **It is the policy and practice of this facility that Resident's who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Also, included in the above but not limited to using the appropriate cleansing solution or soap, with water, during bed bath or showers. Likewise, to apply A & D ointment or lotion at the appropriate time after cleansing the Resident with soap and water.** **It is the responsibility of the Certified Nurse's Aid, (C.N.A.), to use the appropriate cleansing solution or soap when giving bed bath or showers, (The facility uses "total bath" as a hair shampoo as well as a head to toe body skin cleanser while the "perifresh" is use for incontinence and or the perineal and genital area, only). Likewise, bed baths and regular showers should be done properly from head to toe but not limited to, cleansing with the said skin cleanser and rinsed with water properly, including in between the Residents legs that needs to be separated during bathing and or perineal cleaning. It is also improper not to use a skin cleanser solution or just plain water. It should be noted that the perifresh perineal cleanser does not need rinsing with water.** **The Licensed Nurse's will make sure that the above practice and or policy will be implemented and should be checked and followed up during their shift hours of at least twice on their respective shifts.**	

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F 312	Continued From page 11 stated that the certified nursing assistants should be using soap when bathing the residents. b. On January 19, 2012, at 10 a.m., Resident 11 was observed during a bed bath. CNA 1 used a wet cloth with A & D ointment spread on the cloth to wipe the resident off. CNA 1 did not use soap to actually clean the resident during the bed bath. A review of the medical record indicated Resident 11 was admitted to the facility on December 29, 2011, with diagnoses including cerebrovascular accident with left hemiparesis. A resident care plan dated December 29, 2011, addressed Resident 11's decline in physical functioning, needing assistance with his activities of daily living. The nursing interventions included assisting the resident with bathing and personal hygiene. The Minimum Data Set assessment dated January 5, 2012, indicated Resident 11 required extensive assistance from staff with hygiene and bathing. The Care Area Assessment dated January 5, 2012, was triggered due to Resident 11's self-care deficit with his activities of daily living. On January 24, 2012, at 12:10 p.m., CNA 1 stated she used the wet cloth with A & D ointment on it because the resident doesn't like to be touched. She stated it's easier than using water, then soap, then rinsing and then having to apply A & D or lotion. CNA 1 stated Resident 11 fights too much if she takes too long to bathe him so she applies the water and ointment at the same	F 312	**F312** **In addition to the above and as mentioned in the previous deficiency, All Certified Nursing Assistants are no longer allowed to apply medicated ointments and or creams to any Resident's unless it is a plain A & D ointments but it should be applied on the affected area of the Resident's body, not on a diaper and or clothes of the Resident, regardless of a difficult and or a time consuming Resident. It should be noted that all medicated creams and or ointments should be applied by the Treatment/Licensed Nurse on duty at that time.** **The D.S.D. counseled and in serviced the Nurse's who attended Resident 7, 11, & 12, from January 19, 2012 to January 24, 2012 and follow proper procedure to maintain good nutrition, grooming and personal or oral hygiene Likewise may refer to their floor Supervisor for guidance and proper procedure . The rest of the Nursing Staff were in serviced by the DSD of the above issues and completed on - - - - - - - - - - - -** **The DSD will assure continued compliance by checking and following up all of the above Staff of at least twice a day, Mondays to Fridays.**	1/27/12

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F 312	Continued From page 12 time. On January 24, 2012 at approximately 2 p.m., the director of staff development (DSD) stated residents are to be bathed with "Total Bath", a lotionized cleanser. The DSD stated all residents should be bathed with the soap/cleanser. A facility policy on "Bathing a Resident" (no date) indicated the purpose of bathing is to cleanse the skin, prevent skin irritation and breakdown. c1. On January 19, 2012, at 9 a.m., Resident 12 was observed during a bed bath. During the bed bath Resident 12 had a small bowel movement. While bathing the resident private area, CNA 2 failed to open the resident's legs and clean thoroughly. Upon completion of the bath, the surveyor had CNA 2 to go back and clean the resident private area and a small amount of stool appeared on the washcloth. A review of the medical record indicated Resident 12 was admitted to the facility on March 26, 2011, with diagnoses that includes gastrostomy tube feeding and rheumatoid arthritis. A resident care plan dated December 16, 2011, addressed Resident 12's decline in physical functioning requiring assistance with her activities of daily living. The nursing interventions included assisting the resident with bathing and personal hygiene. The Minimum Data Set assessment dated December 22, 2011, indicated Resident 12 required extensive assistance from staff with bathing and hygiene.	F 312		

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F 312	Continued From page 13 On January 24, 2012, at 12:25 p.m., CNA 2 agreed he should have opened Resident 12's legs and thoroughly cleaned the resident private area. He understood the potential risk for infection by not completely cleaning the area. A facility policy and procedure on "Perineal Care" (with no date) indicated the resident's legs should be separated/opened during perineal care. c2. On January 19, 2012, at 9 a.m., CNA 2 used PeriFresh in the water to bathe Resident 12 instead of soap. A review of the instructions on the bottle of the PeriFresh indicated the product was a mild cleanser designed for incontinence use. The directions indicated the product should be applied to the soiled and/or odorous areas. On January 24, 2012, at approximately 2 p.m., the DSD stated PeriFresh should be used for perineal/incontinent care, not for a complete bed bath. The DSD stated all residents should be bathed with the Total Bath soap/cleanser.	F 312		
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.	F 314	**F 314** **It is the policy and practice of this facility that Resident's with a history of pressure sores and or currently harboring pressure sore (s), will receive the necessary treatment and services to promote prevention of new ulcers from developing and healing of current pressure sores. In addition, all treatment modalities and Resident responses are assessed everyday during treatments and the length, width, depthness or circumference are measured on a weekly basis by the Treatment Nurse's and likewise supervised by the Wound Consultant on a monthly basis.** **The facility believes in the principle of "an ounce of prevention is a pound of cure", so we reiterate that the facility will do every measure to prevent the development or worsening of pressure ulcer. Examples of those preventive measures and services are but not limited to;** **1. pressure relieving devices on bed/chair.**	

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F 314	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility nursing staff failed to ensure two of 24 sample residents (6, 8) who had a history of pressure sores and/or had pressure sores receive the necessary treatment and services to promote healing and prevent new ulcers from forming by not providing preventive measures. Findings: a. A review of the clinical record on January 19, 2012, at 11:30 a.m., indicated Resident 6 was readmitted to the facility December 30, 2011 with diagnoses that included dementia, a stage 4 sacrococcyx pressures and a closed blister on the right heel. The resident's Minimum Data Set (MDS a care and screening tool) dated January 13, 2012, indicated the resident's cognition was moderately impaired, his decision-making were poor and dependent on staff for his care needs. A review of the treatment records from January 1 to 25, 2012, indicated the resident was receiving treatments for a closed blister on the right heel. There was a physician's order dated December 30, 2011 for both feet to be elevated with pillow while in bed to off load pressure to heels. This was not observed on January 18 to 20, 2012, at various times during the survey process.	F 314	**F 314** **2. Periodic elevation of the lower extremities as ordered by MD and refer to the Attending MD if the said measure is ineffective, not working, Resident refusal or Resident is unable to maintain the said preventive measure.** **3. Every 2 hour repositioning.** **4. Keeping them clean and dry at all times.** **5. Balanced and adequate diet or as ordered by MD** **6. Adequate or encourage to drink more fluids as long as not contraindicated with the treatment plan.** **7. Refer to the Dietitian for a dietary consult.** **8. Dental Consult and or Speech Consult if ordered.** **9. Refer to MD for any sign and symptoms of infection, or ineffective treatment modality.** **10. Rehab. Referral and or daily isometric/ambulation exercises with RNA as ordered** **11. Medications and treatments as ordered.** **To prevent the re-occurrence of the above deficiency the facility will continue to institute and remind the following measures;**	

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F 314	Continued From page 15 b. A review of the clinical record on January 23, 2012, at 9:30 a.m., indicated Resident 8 was readmitted to the facility April 4, 2007 with diagnoses that included congested heart failure and diabetes mellitus. The resident's MDS dated November 16, 2011, indicated the resident's cognition was severely impaired, decision-making were poor and totally dependent on staff for her care needs. A review of the treatment records dated for the month of December, 2011, indicated the resident had received treatment for a closed blister on the left heel. There was a physician's order dated June 13, 2010, to elevate both feet with pillow while on bed to off load pressure to heels for skin management. On January 19, 2012, at 7:55 a.m., 9:50 a.m., 10:30 a.m., 10:45 a.m., 11:15 a.m., 1:25 p.m. and 2:15 p.m. January 20, 2012 at 7:50 a.m., 11 a.m., Resident 8 was observed lying in bed with both heels flat on the mattress and not elevated. On January 23, 2012, at 8:30 a.m., 9:50 a.m., 11:45 a.m., and January 24, 2012, at 9:10 a.m. and 10:50 a.m., Resident 8 was observed lying in bed with both feet lying flat on the mattress and not elevated. During an interview on January 23, 2012, at 2:40 p.m., Licensed Nurse 3 stated the resident's heels should have been elevated.	F 314	**F 314** **It is the responsibility of the C.N.A.'s , Charge/Treatment Nurses that Resident's are kept clean, dry, probition of bed/chair pressure relieving devices, repositioned every 2 hours, adequate food and fluid intake and referral to the Dietitian/Dental/Rehab. as well as to the Attending MD or Vascular MD.** **The RN supervisors will make sure that the above is implemented. He/She will follow up through every shift rounds and at least twice per shift that above procedure is being implemented.** **The DSD will assure continue compliance through their daily rounds from Mondays to Fridays and at least twice per day.** **F 314** **All Nurses that was involved with Resident 6 & 8 between January 19 & 20, 2012 as well as January 23 &24, 2012, respectively, were counseled and in serviced, by the DSD. He will follow up and check during his daily rounds, from Mondays to Fridays, and at least twice per day.** **In servicing of the rest of the Nursing Staff was done by the DSD and completed on - - -**	2/17/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 16 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident's urinary indwelling catheter was securely anchored to prevent pain from potential pulling tractions and dislodgement of the catheter that may result in urethral (a muscular structure that helps keep urine in the bladder until voiding can occur) trauma for one of 24 sample residents (6). Findings: On January 19, 2012, at 9:55 a.m., during a morning care observation Resident 6 had an indwelling catheter that was connected to a bedside drainage bag. The indwelling catheter was not anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter. A review of the clinical record on January 19, 2012, at 11:30 a.m., indicated Resident 6 was readmitted to the facility on December 30, 2011, with diagnoses that included dementia and	F 315	**F 315** **It is the policy of this facility that Residents are not catheterized unless the Resident's clinical condition demonstrates that catheterization was necessary and a Resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Including, but not limited to, securely anchoring Resident's indwelling Foley catheter, to prevent pain from potential pulling tractions and dislodgement of the Foley catheter that may result in urethral trauma and tears.** **To prevent the re-occurrence of the above deficiency, Licensed Nurse's were in serviced that it is their responsibility to anchor the indwelling Foley catheter's 2-3 inches from the urethra and secure it on the upper thigh of the Resident by using a hypoallergenic tape.** **The RN Supervisor will make sure that the above practice or policy is implemented by checking and following up through his/her shift rounds, and at least twice a day, that the said policy is followed and implemented.** **The DON counseled and in serviced the Licensed Staff who were taking care of Resident 6, between January 19 to 24, 2012, on the proper care including anchoring the said Foley catheter properly to prevent potential trauma or injury.** **The rest of the Licensed Staff were in serviced by the DSD and completed on - - -** 2/20/12	

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F 315	Continued From page 17 possible aspiration pneumonia. The resident's MDS care and screening tool dated January 13, 2012, indicated the resident's cognition was moderately impaired, decision-making were poor and dependent on staff for his care needs. During an interviewed on January 24, 2012 at 10:50 a.m., Licensed Nurse 3 stated she did not remember if the indwelling catheter was taped and that the indwelling catheter should be anchored.	F 315		
F 328 SS=E	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; 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's nursing staff failed to provide proper treatment for foot care for two of 24 sample residents (7 and 11) by allowing the residents to have long sharp toenails and not seeing a podiatrist. This had the potential to cause injury to the residents.	F 328	**F 328** **The facility will continue to honor the policy and practice to ensure that Resident's receive proper treatment and care for the following special services; injections, Parenteral and enteral fluids, Colostomy, ureterostomy, or ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care and prosthetic care including but not limited to Podiatry care. Resident's will be seen, evaluated and treated if needed by the Podiatrist at least every 61 days or as soon as possible according to the Resident's individual needs.** **The contracted Podiatrist has the obligation to document Resident's that was seen for that particular visit, in their individualized medical file under the consult section. The contents of the said documentation should include but not limited to Resident's treatments/medications, diagnosis, assessment/evaluation, acceptance or refusal of the said Resident or refusal to be**	

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F 328	Continued From page 18 Findings: a. On January 19 and January 20, 2012, at 9 a.m., Resident 6 was observed during a bed bath. The resident had long sharp toe nails on both feet. The toenails were approximately 1/4 inches long. A review of the clinical record on January 19, 2012, at 11:30 a.m., indicated Resident 6 was readmitted to the facility December 30, 2011 with diagnoses that included dementia, diabetes mellitus and possible aspiration pneumonia. The resident's Minimum Data Set (MDS a care and screening tool) dated January 13, 2012, indicated the resident's cognition was moderately impaired, decision-making were poor and dependent on staff for his care needs. A review of the Licensed Nurses progress notes dated from January 17, 2012 to January 20, 2012, indicated there was no documentation that the resident had been seen by the podiatrist. An interview was conducted with Registered Nurse (RN 1) supervisor on January 24, 2012, at 10:20 a.m. During the interview he stated the last time the Podiatrist came (one day last week) we ask him to see the resident and he stated he could not because he came to see certain residents. However, RN 1 could not provide any documentation of the conversation with the Podiatrist and there were no Podiatrist progress notes.	F 328	**F 328** **even seen by the Podiatrist and should be tried again in the next visit. Any refusal should be reported to the Social Service Staff and Director of Nurses for follow up to the attending Physician, assistance of the Responsible Party and or proper disposition.** **To prevent re-occurrence of the above deficiency or Resident's from harboring long and unwanted toenails the following discipline's or staff were in serviced that it is the responsibility of all C.N.A.'s, Treatment/Charge Nurse's to advice the RN Supervisor and in turn notifies the Social Service Staff of the need of a Podiatry care ASAP of a particular Resident. The Social Service Staff will in turn alert the Contracted Podiatrist of the needs of a particular Resident and should be seen as soon as feasible.** **The DON will make sure that the above protocol is implemented by following and checking during his daily rounds, from Mondays to Fridays. Likewise, the DON counseled and in serviced the C.N.A.'s, Licensed Nurse's, Social Service and Contracted Podiatrist of Resident 6's podiatry care needs and should be addressed within 7 days, from the date of notification and documented as such by the professional disciplines mentioned above.** **The Administrator/Designee will assure continued compliance by randomly checking with Nursing and or Social Service Staff on a weekly basis during his daily rounds, on Mondays to Fridays.**	

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F 328	Continued From page 19 c. On January 19, 2012, at 9 a.m., Resident 11 was observed during a bed bath. The resident had long toe nails on the first, second and third toe of the left foot. Each toe nail was between 1/4 and 1/2 inch long. A review of the medical record indicated Resident 11 was admitted to the facility on December 29, 2011, with diagnoses including cerebrovascular accident with left hemiparesis. A resident care plan dated December 29, 2011, addressed Resident 11's decline in physical functioning, needing assistance with his activities of daily living. The nursing interventions included assisting the resident with bathing and personal hygiene. The Minimum Data Set assessment dated January 5, 2012, indicated Resident 11 required extensive assistance from staff with hygiene and bathing. The Care Area Assessment dated January 5, 2012, was triggered due to Resident 11's self-care deficit with his activities of daily living.	F 328	**F328** **In services was done by the DSD of all of the concerned Staff and completed on - - - -**	2/17/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	**F 431** **The Facility will continue to abide with the adopted policy from the contracted Pharmacy, that, Drugs and biological 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. The following is also included in the above policy, but not limited to;**	

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F 431	Continued From page 20 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to remove and replace expired medication supply. Surveyor found one emergency medication supply kit containing expired medications and two expired bottles of house supply vitamin liquids, which had a potential to result in more than minimal harm to all of the residents resided in the facility. Findings:	F 431	**F 431** **1. Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.** **2. Contracted Pharmacy shall replace opened or expired E-Kits in any form within 72 hours from notification.** **3. RN Supervisor's and all Licensed Nurse's shall check all E-Kits and stocked medications in locked cabinets, medication/treatment carts, at least one's a week, on Thursdays, and to take out and discard properly and accordingly all expired medications and or biologicals.** **4 Replace all medications that were discarded through the Contracted Pharmacy and or the Facility's Central supply staff.** **The following remedies have been instituted to prevent re-occurrence of the above;** **That it is the responsibility of the Charge Nurse's on all 3 shifts, to check their assigned medication/treatment carts ones a week on Thursdays, and remove any expired medications/biologicals and will be ordered and replaced ASAP through the Contracted Pharmacy or the Facility Central Supply Staff. Also to replace all medications/biologicals that has been used up, properly and accordingly as per policy.** **The RN Supervisors will likewise check all E-Kits, (injectables or orals), and all locked cabinets used as house supplies and remove**	

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F 431	Continued From page 21 On January 19, 2012, 10:45 a.m., during an inspection of the medication room located at the nursing station 2 with the nursing supervisor, there was an emergency medication kit (e-kit) containing injectable medications stored in a lockable cabinet. The label outside of the container indicated the last exchange was on "10/22/11" (October 22, 2011) and an expiration date of "12/11" (December 2011). There was also a content list of 46 medication counts. The surveyor asked the nursing supervisor to open the kit for inspection. Inside the kit, there were a total of eight counts of emergency medications that had expired: one vial of phytonadione 10 mg/ml (Vitamin K, uses include hemorrhagic conditions), expired on "1 DEC 2011"; one vial of naloxone 0.4 mg/ml, expired on "1 JAN 2012"; two vials of prochlorperazine 5 mg/ml, expired in "DEC 2011"; two vials of Lasix 10 mg/ml, expired on "1 DEC 2011"; two vials of Sodium Chloride 0.9%, expired on "1 Jan 2012". On January 19, 2012, at 11:15 a.m., during an inspection of the "over-the-counter" cabinet inside the medication room located at nursing station 2, the nursing supervisor confirmed there were two bottles of Geravim liquid (multi-vitamin) inside the cabinet. Both bottles were labeled to expire in November 2011. The nursing supervisor stated the charge nurse or supervisor should have inspected the medication room about once a week. A review of the "Consultant Pharmacist Report", dated 1/12/12, indicated the pharmacist noted the expired e-kit. During a telephone interview, on January 19,	F 431	**F 431** **all expired medications/biologicals and have it replaced ASAP through the Contracted Pharmacy and or Facility's Central Supply Staff including medication/biological that has been used up and needs replacement. Likewise, it will be done on Thursdays, on all 3 shifts.** **The DON will make sure that the above practice is implemented and will check ones a week in random manner of all Medication/Treatment carts as well as locked cabinets on both Nurses' Stations any day from Mondays to Fridays. This is done to assure non-issuance of expired medications and biological including narcotics.** **The Pharmacy Consultant will assure continued compliance through her monthly visits and or in services.** **In services to all Licensed Nurses was done by the DON and completed on - - - - - - - - -**	2/17/12

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F 431	Continued From page 22 2012. at 1:35 p.m., the pharmacist stated she notified the pharmacy about the expired e-kit on 1/12/12. The pharmacist also stated the e-kit should have been exchanged by the pharmacy within 72 hours. A review of policies and procedures adapted by the facility, presented by the director of nursing, dated January 2009, titled "Facility auditing & removal of expired and discontinued medications", under the "PROCEDURE", number 6, indicated "staff designee will document such inspections with the date and signature..." No such log was present for surveyor. According to the California Code of Regulations, Title 22, section 72357 (l) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 23 (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's nursing staff failed to provide a safe and sanitary environment to prevent the spread of infection. By failing to date Resident 7's oxygen humidifier bottle when it was initially used, this had the potential to cause bacterial growth in the humidifier. When a Certified Nursing Assistant 4 stored a contaminated shower chair that was used by a resident with methicillin resistant staphylococcus aureus (MRSA) in the shower room for two of 24 sample residents (6, 7) and two oxygen concentrators were stored in the oxygen supply storage area with open/used humidifier bottles attached. This had a potential	F 441	**F 441** **The facility will continue to adhere to the policy and practice to 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. In addition to the above, the following is added but not limited to oxygen humidifying bottles and oxygen tubing are changed every week or 7 days to prevent the spread of infection. Likewise, any tubing or humidifying bottles that has been used or that the plastic wrapper has been removed or opened, is already considered used or contaminated and should be changed after 7 days or changed before any other Resident uses it.** **Oxygen humidifying bottles and tubing's will be changed every week on Wednesdays, whether it was changed less than 7 days ago or not. Furthermore, oxygen humidifying bottles and or oxygen tubing may not be marked on the date it was last changed because all of the above paraphernalia are all changed every Wednesdays. This practice is the same if the oxygen humidifying bottle and or oxygen tubing is used by an oxygen tank of any size or an oxygen concentrator. There will be no opened or used oxygen humidifying bottles and oxygen tubing that will be stored in the oxygen room at all times.** **Shower chairs should be disinfected chemically by spraying with "U-1 Plus**	

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F 441	Continued From page 24 for widespread of infection for the residents in the facility. Finding: a. On January 18, 2012, at 12:20 p.m., during initial tour, an undated humidifier bottle was observed connected to the oxygen tank next to Resident 7's bed. During an interview with the Licensed Vocational Nurse (LVN), on January 23, 2012, at 9:45 a.m., the Director of Nurses stated the humidifier bottle should be dated when opened. A review of the clinical record on January 20, 2012 at 9:50 a.m., indicated Resident 7 was readmitted to the facility December 12, 2011, with a diagnoses that included dementia and pneumonia. b. On January 19, 2012 at 11:15 a.m., certified nursing assistant 4 (CNA 4) was observed transferring Resident 6 in a shower chair to take him for a shower. Resident 6 was in contact isolation and the CNA took Resident 6 in the shower room in the shower chair and returned to the room. When the CNA was done with the shower chair he took the chair and placed in the shower room without disinfecting the chair. A review of the clinical record on January 19, 2012, at 11:30 a.m., indicated Resident 6 was readmitted to the facility on December 30, 2011 with diagnoses that included dementia and possible aspiration pneumonia.	F 441	**F 441** **Mint #100" and wiping it dry with a paper towel before and after use by any Resident.** **The following practice has been instituted to prevent the spread of infection among Residents and Staff.** **It is the responsibilities of the RNA"s, to change all oxygen humidifying bottles and oxygen tubing's that is in use or the plastic wrapper is opened/removed, every, Wednesdays of the week. Likewise any used or opened humidifying bottles and tubing's will be discarded before storing all oxygen tank and or concentrator inside the Oxygen Room, unless it is in sealed plastic wrapper or unopened plastic wrapper.** **The Licensed Nurses will make sure that the above policy will be implemented and will be checked randomly during their daily rounds of their Residents.** **The DSD in serviced and counseled the R.N.A.'s and Licensed Nurse's on infection control in relation to, Resident's 6 & 8, on January 19, 23,& 25 respectively. Also, he will assure continued compliance during his daily rounds from Mondays to Fridays and in services.** **In services was done by the DON to all R.N.A.'s and Licensed Staff in regards to infection control and completed on - - - - - -**	2/22/12

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F 441	Continued From page 25 During an interviewed on January 23, 2012, at 10:20 a.m., Registered Nurse 1 stated the shower chair should have been cleaned before placing the chair back into the shower room. c. On January 25, 2012, at 9 a.m., during general observations of the oxygen storage area there was one oxygen concentrator with open/used humidifier attached with oxygen tubing on station 2b and on station 1b in the oxygen storage area there was one oxygen concentrator with open/used humidifier attached. On the same date during an interview with the staff developer he stated he did not know if the humidifiers were clean or not. He agreed the oxygen concentrator with an open/used oxygen humidifier should not be placed in the clean oxygen area.	F 441		
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	F 514	**F 514** **The facility will continue to 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.** **Included in the above protocol are the following but not limited to;** **Residents who are receiving any form of chemical restraints, physical restraints as well as prolonged use of a device will have a verified/confirmed informed consent at the time of admission or at the time it was ordered. All of the above parties will be informed and approves the usage of the above, starting from the Attending Physician/Psychiatrist.**	

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F 514	Continued From page 26 by: Based on observation, interview and record review, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete. There was no Informed Consent for the use of physical restraint (bed side rails) for one of 24 residents (2). This deficient practice had the potential to make the resident be not informed of the use of restraints. Finding: On January 19, 2012, a review of the medical record indicated Resident 2 was originally admitted to the facility on November 10, 2011, and was readmitted to the facility on January 11, 2012 with diagnoses that includes muscle weakness and diabetes mellitus (high blood sugar). A physician's order dated January 12, 2012, indicated Resident 2 was to require the bed side rails to be up when the resident is in bed. Record review indicated there was no Informed Consent for the use of bedside rails in Resident 2's medical record. On January 24, 2012 at 10:45 a.m., review of Resident 2's medical record with RN supervisor 1 there was no Informed Consent in the record. RN supervisor 1 stated the side rails were used for mobility and consent is needed unless the side rails are used for safety. The facility's Side Rail policy with no date	F 514	**F 514** **Resident/Responsible Party and the Facility Representative through the Licensed Nurse.** **The Facility has revised the informed consent form that will be used by the facility with a "Korean" translation at the back of the said consent form.** **It is the responsibility of the Attending Physician to secure a verified informed consent for the proposed treatment such as Physical Restraint, Psychoactive Medication or Prolonged Use of a Device to the Resident/Responsible Party.** **He/She will explain and reviews the California Code of Regulations, Title 22 Sections (a), (b) & (c) before giving a verified informed consent to the facility.** **It is the responsibility of the Licensed Nurse to verify and clarify the verified informed consent from the Resident/Surrogate Decision Maker. Upon verification/clarification from the above Resident/Surrogate Decision Maker, the Licensed Nurse fills out the verified informed consent form properly and then the said proposed treatment can now start to be given and or applied. A Resident will not be able to receive/apply the above proposed treatment, if the above consent form has not been properly filled out by the Licensed Nurse at the time of admission or at the time it was ordered.** **The RN Supervisor will make sure that the above practice or policy is implemented by going over newly admitted Resident's or**	

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F 514	Continued From page 27 indicated a physician's order and a consent is needed to elevate one or both side rails for safety or as an enabler.	F 514	**F 514** **new orders for a Physical/Chemical or a Prolonged used of a device.** **He/She should check and verify that the consent form has been properly filled out.** **The DON will assure continued compliance by checking randomly all Resident's that is newly admitted or Resident's who just had a new order for a Chemical/Physical restraint as well as a Prolonged use of a device, and the verified and confirmed informed consent is in order before giving the medication/treatment/device to the said Resident.** **Also, the word "mobility" that is related to the use of a side rail has been changed to "enabler" as define in the facility policies and procedure. Enabler is use to assist a Resident when repositioning self while in bed by grabbing the side rail(s). A consent is not needed if the said bed rail is used as an enabler and not a physical restraint.** **Likewise, The Medical Records Staff will make sure that the above forms will be filled out properly and timely or else it will be included in their daily audits.** **All of the above Personnel were in serviced by the DON and completed on - - - - - - - - -**	2/23/12