STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555137	A. BUILDING _____ B. WING _____	09/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANCELL VILLAGE	7150 TAMPA AVE RESEDA, CA 91335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification Survey Representing the Department of Public Health: Surveyor Federal ID No. 09697, RN. HFEN Surveyor Federal ID No. 22303, RN. HFEN Surveyor Federal ID No. 25046, RN. HFEN Surveyor Federal ID No. 36291, RN. HFEN Surveyor Federal ID No. 07598, REHS. HFE-I Resident Census: 102 Resident Sample: 21	F 000	"This Plan of Correction constitutes my written credible allegation of compliance. Submission of the Plan of Correction is not an admission of any fact or that any deficiency whatsoever exists or that any deficiency was cited correctly."	
F 176 SS=D	Highest S/S = D 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility's interdisciplinary (IDT) failed to ensure that Resident 16 would not be allowed to keep medications at the bedside without being assessed to determine the resident's capacity to safely self-administer and safely keep the medication at the bedside for one of 21 residents (Resident 16).	F 176	F 176 1. Upon notification the medication was removed from the bedside by the licensed nurse. 2. The Licensed Nurse assessed Resident 16 for self- administration. The resident's orders and plan of care were updated to reflect the self- administration of medication. 3. The IDT conducted rounds to ensure no medications were at bedside of in house residents. No other issues were noted. The Director of Nursing conducted in-service to Licensed Nurses on 09/13/2016 regarding medications at bedsides and self – administration. The RN supervisors will monitor for compliance through observation rounds daily. Identified issues will be forwarded to the IDT to be addressed as per policy.	

2016 SEP 23 PM 1:30
LOS ANGELES COUNTY
HEALTH FACILITIES
DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9-23-2016

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 176	Continued From page 1 Findings: On September 8, 2016, at 6 p.m., during the initial tour in the presence of Licensed Vocational Nurse 2 (LVN 2), a bottle of eye drop medication was observed at Resident 16's bedside table. The resident was asked if she was using the eye drop medication (Cosopt eye drops- one drop both eyes twice a day). She responded she was using it. LVN 2 present during the observation, indicated there was an order for the eye drop medication. On September 9, 2016, at 6 p.m., during an interview with Registered Nurse 1 (RN 1) and review of the clinical record it was revealed there was no documentation to indicate the resident was assessed by the IDT that Resident 1 was assessed and determined she was capable to self-administer medication. A review of Resident 16 clinical record, indicated that she was readmitted to the facility on October 8, 2015, with diagnoses taken as hypertension (high blood pressure), glaucoma and anemia. On November 1, 2015, there was an order for Cosopt eye drops - to administer one drop both eyes twice a day. According to the Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated July 21, 2016, indicated the resident's short and long-term memory is intact and required supervision with her activities of daily living. According to the facility's policy of Self-Administration of medication, it is stipulated that the physician or licensed independent	F 176	F 176 (continued) 4. The Director of Nursing or designee will report trends of non-compliance related to medication self -administration to the QAPI committee for evaluation and recommendation. 5. Corrective actions will be completed by September 23rd, 2016.	

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F 176	Continued From page 2 practitioner determines that it is safe to self-administer medication.	F 176		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: 1. Effectively manage resident's pain by not assessing the pain level and the effectiveness of the pain medication after the administration of pain medication and not providing further interventions when the pain medication was not effective. 2. Ensure Resident 8's sheepskin both side rails was applied as ordered by the physician in order to pad to protect skin tear. These deficient practices had the potential unresolved pain (Resident 1) and the potential for additional skin bruising (Resident 8) for two of 21 sample residents (Residents 1, 8). Findings: a. According to the admission record, Resident 1	F 309	F 309 1. Resident 1 that was affected by not re-assessing pain level after pain medication was given, was immediately re-assessed upon notification. Resident 8 was provided right side rail padding immediately upon notification. 2. All current residents that have orders for pain medication were reviewed to ensure monitoring of effectiveness and no other deficient practice was identified. All current residents that have orders for side rail paddings were checked by licensed nurse to ensure padding was in place and no deficient practice was identified. 3. An in-service was provided to the Licensed Nurses by our Licensed Pharmacy Consultant on the proper medication administration including assessing pain level, utilizing the pain scale, prior and after administration for effectiveness and documenting appropriately and timely in the MAR on September 10th, 2016. An in-service was provided by the DNS on September 13th, 2016 regarding checking the side rails of patients with orders for padding and ensuring that padding is in place. The DSD and RN supervisors will monitor for compliance during routine shift rounds to ensure plan of care and orders for padded side rails are carried out accordingly. Any deficient findings will be addressed immediately.	

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F 309	Continued From page 3 was admitted to the facility on August 18, 2016, with diagnoses that included malignant neoplasm of uterus, hypertension, and hydronephrosis. The Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated August 25, 2016, indicated the resident had intact cognitive skills for daily decision making, needed extensive assistance from the staff for the activities of daily living except in eating. A review of the admission pain assessment dated August 18, 2016, indicated the resident had aching pain on lower abdomen caused by metastatic uterine cancer. The second page of the pain assessment was blank including the resident's acceptable pain level, and what could make the pain level better or worse. The resident had the following physician's orders for pain: 1. Tylenol 325 milligram (mg) two tablet by mouth every 4 hours for mild pain- dated August 19, 2016. 2. Percocet 5-325 mg one tablet by mouth every 4 hours as needed for moderate pain - dated August 19, 2016. 3. Percocet 5-325 mg two tablet by mouth every 4 hours as needed for severe pain - dated August 19, 2016. 4. Morphine concentrate solution (20 mg/ml) 5 mg by mouth every 2 hours as needed for severe pain, and to give only if Percocet is ineffective. There was a plan of care developed on August	F 309	F 309 (continued) 4. The results of DSD and RN Supervisor rounds will be reviewed with the DNS and appropriate follow up will be implemented. The DSD will be responsible to report deficient findings to the Quality Assurance and Performance Improvement Committee for recommendation and effective resolutions. 5. Corrective actions will be completed by September 23rd, 2016	

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F 309	Continued From page 4 18, 2016, for alteration in comfort and pain related to end stage carcinoma of the uterus with metastasis. One of the interventions was to administer medication as ordered (Morphine Sulfate, Percocet, Tylenol) and to observe for efficacy or lack thereof and to notify the physician of unresolved pain/discomfort promptly when noted. On September 9, 2016, at 6 p.m., Resident 1 was observed lying in her bed. During an interview with the resident at the same time, she stated she did not feel good with pain. A review of the Medication Administration Record (MAR) for the month of September 2016 indicated the resident was administered one tablet of Percocet 5-325 mg on following days. 1. On September 2, 2016, at 1:46 p.m., the resident was administered one tablet of Percocet 5-325 mg for pain level 8 on a pain scale from zero to ten (8/10). There was no assessment of pain level after Percocet was administered on a pain scale. It was just indicated " effective. " Also, there was no pain location indicated. 2. On September 4, 2016, at 8:55 a.m., the resident was administered one tablet of Percocet 5-325 mg for pain level 7/10. There was no assessment of pain level after Percocet was administered on a pain scale. It was just indicated "effective." Also, there was no pain location identified. 3. On September 4, 2016, at 1:23 a.m., the resident was administered one tablet of Percocet 5-325 mg for generalized pain with pain level 5/10. It was indicated the pain level was still 5/10	F 309		

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F 309	Continued From page 5 after the medication was administered. However, there was no documented evidence further intervention was implemented when the resident's pain level remained the same. 4. On September 6, 2016, at 12:15 a.m., the resident was administered one tablet of Percocet 5-325 mg for generalized pain with pain level 6/10. It was indicated the pain level was still 6/10 after the medication was administered. However, there was no documented evidence further intervention was implemented when the resident's pain level remained the same. On September 10, 2016, at 10:40 a.m. during an interview with Registered Nurse 3 (RN 3), he was not able to provide the documented evidence the resident's pain level was assessed on a pain scale after one tablet of Percocet was administered to ensure the effectiveness of the medication, and whether further interventions were implemented when one tablet of Percocet was in effective. RN 3 stated pain assessment should have been done using pain scale after the pain medication was administered, and further interventions should have been implemented when the pain medication was ineffective. A review of the facility's policy of the "Pain Management" indicated the licensed nurse should assess the resident's pain utilizing the pain scale. The licensed nurse should administer as needed medication as ordered and document on the MAR the resident's/patient's response, effective or not effective and subsequent pain scale to medication within one half hour. b. On September 8, 2016, a review of Resident 8's clinical record indicated the resident was admitted to the facility on July 7, 2015, with	F 309		

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F 309	Continued From page 6 diagnoses taken as encephalopathy and dementia. The MDS dated July 7, 2016, indicated Resident 8's cognitive status was impaired and required extensive assistance with her activities of daily living. According to the skin assessment Resident 8 was identified to be high risk of bruising and pressure sore. On September 8, 2016, at 6 p.m., during initial tour, Resident 8 was observed on bed. Her left ½ side rail was padded with sheepskin. The right side rail was not padded. On September 9, 2016, at 5:30 to 7:30 p.m., Resident 8 was observed on bed. There were bruised spots on her right arms. The right side rail was still bare. On the same date at 7:45 p.m., RN 1 was interviewed, regarding sheepskin pad for Resident 8. She responded both side rails should have been padded with sheepskin to prevent from bruising. RN 1 and RN 2 proceeded to Resident 8's room and observed the right side rails has no pad. RN 1 and RN 2 found the sheepskin pad in Resident 8's drawer.	F 309		
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	F 314	F 314 1. The treatment nurse for Resident 2 was provided 1:1 re-eduation training by the Director of Nursing on September 11th, 2016.	

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F 314	Continued From page 7 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 ensure a single linen was properly placed on a low air loss (LAL) mattress for a resident who had a Stage IV pressure ulcer (is a very deep, reaching into muscle and bone and causing extensive damage; damage to deeper tissues, tendons, and joints may occur), on sacrococcyx area for one of 21 sample residents (Resident 2). This deficient practice can prevent a resident from receiving the maximum benefit of the Low-Air-Loss Mattress (a pressure reliving device) and can prevent wound healing. Findings: According to the Admission Record, Resident 2 was admitted on May 17, 2015, and readmitted to the facility on May 15, 2016, with diagnoses including Stage IV pressure ulcer on sacral region, hypertension, and osteoarthritis. The Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated August 19, 2016, indicated the resident had intact cognitive skills for daily decision making, needed total assistance from the staff for activities of daily living except in eating, and had one Stage IV pressure ulcer. There was a plan of care developed on June 17, 2015, for Stage IV pressure ulcer on sacrococcyx area. One of the approach plans was to place	F 314	F 314 (continued) 2. Licensed Nurses conducted rounds on all Low Air Loss mattress utilized by residents on 9/11/2016. No other deficient practice was identified for current residents. The DNS conducted in-service training on the facility policy and protocol for LAL mattress including prevention of multiple linen layers. 3. The DSD, DNS, and RN supervisors will observe for compliance during routine rounds. The wound consultant will observe for compliance during regular scheduled facility visits and provide summary report the the DNS for follow up as needed. 4. The DSD or designee will provide a summary trend report of the round findings to the QAPI Committee for evaluation and recommendation. 5. Corrective actions will be completed by September 23rd, 2016	

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F 314	Continued From page 8 Low-Air-Loss Mattress as ordered. On September 10, 2016, at 11:05 A.M., during treatment observation for Stage IV pressure ulcer on the resident's sacro coccyx area by Licensed Vocational Nurse 3 (LVN 3), Resident 2 was observed lying on a Low Air Loss Mattress (LAL), and there were 5 layers between the resident's wound and the LAL mattress. The 5 layers included three layers of chux (which was made from one chux folded in 1/3), and 2 layers of linen (which was made from one linen folded in half). During an interview with LVN 3 at the same time, she was not sure how many layers could be placed on the LAL mattress, and stated the nursing staff had folded the chux and the linen because the resident was incontinent in bowel and bladder. A review of the facility's policy of the "Patient/Resident Pressure Redistribution Devises-Air-Loss-Mattresses" dated August 2015 indicated only one flat sheet or a specialty air loss "chuck" may be placed between mattress and the patient/resident.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and	F 322	F 322 1. The resident that was affected by the deficient practice was attended to and there was no adverse effects.	

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F 322	Continued From page 9 (2) 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 the administration of the correct volume of gastrostomy [GT- a tube inserted into the stomach through a surgical incision] feeding formula as the physician ordered, and to elevated a resident's head while receiving GT formula for a resident who had via gastrostomy tube (GT) for one of 21 sample residents (Resident 3). These deficient practices place the resident at risk for a potential weight loss and pulmonary aspiration (entry of the foreign bodies in to the lungs). Findings: a. According to the admission record, Resident 3 was initially admitted to the facility on December 17, 2005, and readmitted on May 23, 2016, with diagnoses that included cerebrovascular disease, dysphagia, and gastrostomy status. The Minimum Data Set [MDS- a comprehensive	F 322	F 322 (continued) 2. Resident 3 was reviewed by Registered Dietician and there was no weight loss and has been stable. The Registered Dietician as part of the monthly audit reviewed other in-house residents receiving G-Tube findings and determined there were no other adverse effects. The Licensed nurses assessed the in-house residents receiving g-tube feedings for any signs or symptoms of pulmonary aspiration. Residents on g-tubes were reviewed to ensure the head of bed was elevated at least 30 degrees. 3. An in-service was provided by the Director of Nursing for the licensed nurses regarding the following of doctors' orders for g-tube feeding including the importance of following the schedule to dispense the correct cc's per hour, potential risks and elevation of the bed. The RN Supervisors will conduct as part of daily rounds a review of cc's dispensed and bed elevation for residents on g-tube feedings. Any deficient findings will be addressed if noted for immediate correction. 4. For on-going compliance the Registered Dietician will report to QAPI committee a review of in-house residents receiving g-tube feedings and will address negative trends if identified. The IDT will make recommendations for timely resolution if deemed necessary. 5. Plan of correction will be completed by 09/23/2016.	

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F 322	Continued From page 10 assessment and screening tool] dated July 21, 2016, indicated the resident was severely impaired in cognition, and needed extensive to total assistance from the staff for the activities of daily living. Feeding tube was used for nutrition. A review of the physician's order dated February 17, 2016, indicated to provide Glucerna 1.2 at 60 cc's per hour for 20 hours via GT pump to provide 1200 cc/1440 Kcal per day. There was a plan of care developed on January 25, 2016, for GT feeding being and potential aspiration, dehydration. The approaches were to provide GT feeding as ordered, and to keep the head of bed elevated at least 30 degrees at all times. On September 8, 2016, at 6:35 p.m., Resident 3 was observed lying in her bed. The resident had a GT that was connected to the GT formula bottle (Glucerna 1.2). The GT formula bottle was hung on a pole and connected to a GT feeding pumping machine, that was turned on. There was approximately 800 cubic centimeters (cc's) of formula in the bottle, and it was labeled on the bottle that it had been started on September 7, 2016, at 10 p.m. During an interview with LVN 3 at the time of the observation, she stated Resident 3's GT pump was turned on at 2 p.m., and to be turned off at 10 a.m. After calculation, LVN 3 stated Resident 3's GT infusion schedule was behind by 290 cc's during 4 ½ hours period. LVN 3 stated the GT formula should have been given to the residents as the physician ordered. b. On September 9, 2016, at 7:20 p.m., Certified Nursing Assistant 1 (CNA 1) was observed providing peri-care, changing Resident's clothes	F 322		

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F 322	Continued From page 11 and repositioning while Resident 3 was receiving GT formula in the bed in flat position, for approximately 10 minutes that placed the resident at risk for pulmonary aspiration. During an interview, CNA 1, stated she should have asked the charge nurse to turn the GT pumping machine off before she provided care to the resident, but she forgot. A review of the facility's policy of Enteral Feeding indicated to elevate the head of patient's bed at least 30 degrees if the resident is laying down.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to place floor mats for a resident who was at risk for fall for one out of 21 sample residents (Resident 14). This deficient practice place the resident at risk for potential injury in the event of a fall. Findings: On September 9, 2016, at 7:45 p.m., Resident 14 was observed sleeping in her low bed. There	F 323	F 323 1. The landing pads for Resident 14 were placed next to the bed on both sides on September 9th, 2016 when identified. 2. Licensed Nurse conducted rounds on a 9/9/2016. No other deficient practice was identified with this finding. The Director of Nursing designee provided in-service training to the licensed nurses on September 13th, 2016 and CNA staff on September 21st, 2016 regarding ensuring interventions are placed/ implemented as per the plan of care and orders. 3. The DSD and RN supervisors will monitor for compliance during routine shift rounds and address items as appropriate ongoing to ensure compliance. 4. The DSD will provide a summary trend report of the round findings to the QAPI Committee quarterly for re-evaluation and recommendation as needed. 5. Corrective actions will be completed by September 23rd, 2016	

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F 323	Continued From page 12 were no floor mats placed next to the resident's bed, but two folded floor mats were observed standing against the wall, behind the door. During an interview with Licensed Vocational Nurse 4 (LVN 4), she was not sure whether floor mats should be placed next the resident's bed. According to admission record, Resident 14 was readmitted to the facility on September 2, 2016, with diagnoses that included hypertension, anemia, dementia, and generalized muscle weakness. The Minimum Data Set [MDS-a comprehensive assessment and screening tool] dated July 22, 2016, indicated the resident had severely impaired cognition, and needed limited to extensive assistance from the staff for the activities of daily living. A review of the fall risk predictive assessment dated July 27, 2016, indicated the resident was assessed at high risk of fall. There was a plan of care initiated on February 28, 2016, for actual fall with interventions that included to place floor mattresses and a bed-alarm while in chair . On September 9, 2016, at 8 p.m., during an interview, Registered Nurse 3 (RN 3), when asked stated floor mattresses should have been place on both right and left side of the resident's bed when the resident was in the bed. A review of the facility's policy of the "Fall Reduction/Prevention Program," indicated the Inter-disciplinary team (IDT) will review the medical record and all other factors that may	F 323		

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F 323	Continued From page 13 result in the resident's fall, and create an appropriate individualized care plan to address each resident's needs and goals with interventions specific to the root cause of the fall. It was indicated placing landing pads were included in the examples of interventions.	F 323		
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; 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: 1. Ensure that residents received the volume of oxygen as ordered by the physician. Resident 20 received two and one-half liters of oxygen instead of two liters as ordered by the physician. Random Sample Resident 23 (RSR 23) received four liters of oxygen instead of two liters as ordered by the physician. 2. Ensure a humidifier was attached to a nasal cannula while RSR 23 received oxygen therapy at a flow greater than 3 liters/minute to prevent	F 328	F 328 1. The oxygen volume for Resident 23 was adjusted to the correct amount immediately upon notification. No adverse effects were noted. 2. Licensed Nurse conducted rounds on 9/10/2016 to ensure that other in-house residents had oxygen volumes as ordered, and residents had humidifiers attached to the nasal cannula as appropriate. No other deficient practice was identified with this finding. 3. The DNS provided in-service training the Licensed Nurses on the proper protocol of oxygen therapy which included the following; physicians orders, frequency, duration, method used, saturation parameters, and use of humidifiers when appropriate on September 21st, 2016. 4. The DSD and RN supervisors will monitor for compliance during routine rounds and address findings as appropriate ongoing to ensure compliance. The DSD or designee will report findings to the DNS for appropriate follow up and provide a summary trend report of the round findings to the QAPI Committee quarterly for re-evaluation and recommendation as needed. 5. Corrective actions will be completed by September 23rd, 2016	

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F 328	Continued From page 14 dryness of the mouth and the nostrils. These deficient practices had the potential to cause complication associated with oxygen therapy for one of 21 sample residents (Resident 20) and for one RSR (23). Findings: a. On September 8, 2016 at 6:15 p.m., during initial tour of the facility, Resident 20 was observed sitting in her wheelchair, awake, alert, and playing cards with her daughter. The resident was receiving two and one-half liters of oxygen a via nasal cannula (a plastic tube that delivers oxygen directly to the resident's nares). A review of the admission record indicated Resident 20 was admitted to the facility on September 6, 2016 with diagnoses that included pneumonia (an inflammatory condition of the lung), chronic heart failure with exacerbation (a condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs, and atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating). A review of the Resident 20's physician's orders dated September 6, 2016, indicated an order for the resident to receive oxygen via nasal cannula at two liters per minute continuously. However, on September 8, 2016 at 6:15 p.m., Resident 20 was observed receiving two and one-half liters of oxygen which was ½ liter more than the physician had ordered. RN 1 present during the observation confirmed the resident was on two and one-half liters of oxygen per minute.	F 328		

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F 328	Continued From page 15 A review of Resident 20's care plan dated September 7, 2016, for respiratory system related to aspiration pneumonia indicated the goal is for the resident to verbalize ease of respiration. Interventions included to assess and monitor quality of the resident's breath and provide oxygen as ordered. b. On September 8, 2016, at 6:00 p.m., during the initial tour of the facility, RSR 23 was observed in bed, sitting in high fowler's position (is a standard patient position used as an intervention to promote oxygenation via maximum chest expansion), awake, alert and watching television. The resident's breathing was unlabored, and had a wheezing sound during exhalation. The resident's oxygen tubing was directly connected to the wall oxygen outlet set at four liters per minute. There was no humidifier attached while the resident received four liters per minute which was two liters more than what the physician had ordered. RN 1 was present during this observation and confirmed the setting of four liters per minute. A review of the admission record indicated RSR 23's was re-admitted to the facility on August 30, 2016, with diagnoses that included End-Stage Colon Cancer, shortness of breath, and wheezing (a high pitched whistling sound made while breathing). RSR 23 had a physician's orders dated August 30, 2016, for oxygen at 2 liters via nasal cannula as needed for shortness of breath and or comfort. However, at the time of the observation on September 8, 2016, at 6:00 p.m., RSR 23 was receiving four liters per minute without a	F 328		

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F 328	Continued From page 16 humidifier. A review of the current accepted standard of practice indicated, when oxygen is administered at a flow rate greater than three liters/minute use of a humidifier to prevent drying of nasal mucosa (Swearingen, Pamela, et al. Nursing Procedures, Third Edition, Pages 343). A review of the facility's policy and procedure titled "Oxygen Therapy" and dated February 2011 indicated that a humidifier is to be used when oxygen delivery is three liters per minute or greater.	F 328		
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by:	F 368	F 328 1. The facility has developed a tracking log for bed time snacks, the log will incorporate which snack was provided. The DNS has provided an in-service to the Licensed Nurses on September 13th, 2016 and C.N.A. staff on September 21st - 23rd, 2016 regarding the offering of bed time snacks and log system. 2. The charge nurses or RN supervisors will monitor for compliance by checking and follow up as needed during shift rounds on evenings. 3. The RN supervisors will monitor for compliance during routine evening rounds and address findings as appropriate ongoing to ensure compliance. 4. The DSD will be responsible for continued compliance and will provide a summary trend report of the bedtime snack process to the QAPI Committee for re-evaluation and recommendation as needed. 5. Corrective actions will be completed by September 23rd, 2016	

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F 368	Continued From page 17 Based on interview, the facility's nursing/dietary staff failed to ensure facility residents' were offered bed time snacks after the dinner and before bedtime. This deficient practice placed residents' at risk of being hungry before breakfast was served the next day. Findings: On September 10, 2016, at 10:15 a.m., during a group meeting seven out of 11 residents who attended the group meeting/Interviews stated they were not offered evening snacks. They also stated that they were not aware that the nursing or kitchen staff should be going to their rooms and offer them with snacks. On September 10, 2016, at 2 p.m., during an Interview, the Dietary Services Supervisor (DSS) stated they leave the a food tray of snacks and nourishments for residents at the Nursing Station at 6:30 p.m., and at 7 p.m., and the nursing staff should have offered the snacks to the residents every night.	F 368		
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	F 425	F 425 1. Residents 22 and 6, affected by the deficient practice were immediately reviewed and there was no identified change of condition. 2. All residents have the potential to be affected by the deficient practice. Director of Nursing provided education to the licensed nursing staff regarding facility P&P of medication administration including timeliness of medication pass and documentation. Pharmacy Consultant provided an in-service to the licensed nursing on September 10th, 2016, regarding P& P medication administration.	

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F 425	Continued From page 18 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Random Sample Resident 22 (RSR 22) received medication as ordered by the physician for one randomly sample resident (RSR 22) and failed to administer Resident 6's medication at the scheduled time and/or within 60 minutes before or after the medication administration scheduled time. This deficient practice resulted in medication errors for one sample resident and for one random sample resident (Resident 6 and RSR 22). Findings: a. During a medication pass observation on September 9, 2016, at 5:25 p.m., Licensed Vocational Nurse 3 (LVN 3) administered three medications to RSR 22. A review of the resident's record during reconciliation of the medication pass revealed the omission of Saccharomyces boulardii (used for treating and preventing diarrhea	F 425	F 425 (continued) 3. The Clinical IT specialist, RN provided an in-service to license nurses regarding electronic health record, medication pass and documentation including reasons for late administration on September 15th, 2016. 4. For on-going compliance the RN Supervisors will review medication administration record for compliance and will report identified concerns to the Director of Nursing. The Director of Nursing will be responsible for on-going compliance and will report to QAPI for recommendations as needed. 5. Corrective actions will be completed by September 23rd, 2016	

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F 425	Continued From page 19 digestive-disorders/digestive-diseases, and general digestion problems, irritable bowel syndrome,inflammatory bowel syndrome) 250 milligram (mg) one capsule was to be given twice a day. During an interview with LVN 3 on September 9, 2016, at 6:15 p.m., she verified that the resident should have been administered one capsule of Saccharomyces boulardii 250 mg as ordered by the physician. b. On September 9, 2016, a review the admission record indicated Resident 6 was admitted to the facility on August 9, 2016, with diagnoses that included respiratory failure, hypertension, pneumonia and history of falling. A review of the Minimum Data Set [MDS- a comprehensive assessment and screening tool] dated August 15, 2016, indicated Resident 6 was severely impaired with his cognitive skills for daily decision making and required extensive assistance by staff with activities of daily living. A physician's order dated August 9. 2016, to administer Potassium Chloride 20 meq one tab twice daily. A review of Resident 6's Medication Administration Record sheet dated September 2, 3 and 4, 2016, indicated to administer Potassium Chloride 20 meq at 4 p.m., but, LVN 3 administered the Potassium Chloride medication at 7 p.m. the same days. There was no documented evidence for the reason why LVN 3 administered the Potassium Chloride medication four hours late. During an interview with LVN 3 on September 9,	F 425		

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F 425	Continued From page 20 2016, at 8 p.m., he stated he had to wait for the resident until the resident was ready to take the Potassium Chloride medication. He also stated that he did not mention to the nursing staff and the physician regarding late administration of the mentioned medication. On September 10, 2016, at 9 a.m., during an interview with the Director of Nursing (DON), she agreed that medications being administered should be within 60 minutes before or after the medication administration scheduled time. A review of the facility's policy of the Medication Administration Times indicated unless otherwise specified by the physician, medications are administered within 60 minutes before or after the facility's medication administration schedule, except orders for before or after meals.	F 425		