STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055408	A. BUILDING _____ B. WING _____	02/22/2014

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BELLFLOWER CONVALESCENT HOSPIT	9710 E. ARTESIA AVE BELLFLOWER, CA 90706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a refortification survey. Representing the California Department of Public Health: Evaluator ID No: 27812, RN, HFEN Evaluator ID No: 28114, RN, HFEN Evaluator ID No: 12007, REHS, HFE Total Resident Population: 43 Total Resident Sample: 11 + 1 RSR Highest Scope and Severity: E Abbreviations: DON: Director of Nursing RN: Registered Nurse LVN: Licensed Vocational Nurse CNA: Certified Nursing Assistant DSS: Dietary Service Supervisor MS: Maintenance Supervisor MDS: Minimum Data Set (Standardized Assessment and Care Planning Tool) ADLs: Activities of Daily Living RSR: Randomly Selected Resident	F 000	**Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence no later than 03/22/14.** **Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907.** [redacted] **(Initials)** RECEIVED 2014 MAY 15 PM 1:34 HEALTH FACILITIES ADMINISTRATION	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	F 154	**F154 – It is the policy of this facility to ensure that a resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.**	3/7/14

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 5/16/14

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

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F 154	Continued From page 1 The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the physician obtained the informed consent (a legal procedure to ensure that the residents and their legal representative are aware of all the potential risks and costs involved in a treatment or procedure) from the legal representation prior to the administration of psychoactive medication (chemical substances that affect the brain functioning, causing changes in behavior, mood and consciousness) for two of 11 sampled residents (7 and 10). For Resident 7, the facility's physician failed to explain the risk and benefit to the resident's responsible party prior initiating anti-anxiety medication (Ativan). For Resident 10, the facility's physician failed to explain the risk and benefit to the resident's public conservator prior initiating antipsychotic medication (Haldol). This failure had the potential to result in lack of knowledge regarding risk and benefits of the antipsychotic medication and alternative therapies. Findings: 1 A review of Resident 7's clinical record indicated the resident admitted to the facility on	F 154	**CORRECTIVE ACTION** 1. Informed consent for Resident 7's Ativan was obtained from her niece (responsible party) by the attending physician on 2/28/14. 2. Informed consent for Resident 10's Haldol was obtained from his public conservator (responsible party) by the attending physician on 2/28/14. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents on psychoactive medications without prior informed consents obtained were affected by this deficient practice. On 3/3/14 the Director of Nursing (DON) and designated licensed nurses reviewed the medical records of all residents currently receiving psychoactive medications to identify whether or not informed consents were obtained by their physicians; no additional residents were affected. **SYSTEMIC CHANGES** The DON gave an in-service to all licensed nurses on 3/7/14 regarding the facility's responsibility in verifying that informed consents were obtained from the resident/responsible party once the physician explains the risks versus benefits and prior to the initiation of psychoactive medications. In addition, the Medical Records Designee (MRD) will monitor nursing's compliance with informed consents requirements via chart audit and monthly	

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F 154	Continued From page 2 4/9/10 with diagnoses including schizophrenia (a disorder characterized by a breakdown in thinking and poor emotional responses) and hypertension (high blood pressure). The resident had her niece as the responsible party. According to the Minimum Data Set (MDS-Resident assessment and Care Screening Tool) dated 1/22/14 indicated Resident 7 had cognitive impair and required total dependence on staff for transferring, dressing, toilet use and personal hygiene. A review of the physician's order, dated 8/26/13, indicated to administer Ativan 0.5 milligrams (mg) by mouth (PO) at bedtime (QHS). A review of the Consent for the administration of psychoactive medication indicated the informed consent was not obtained from the resident's responsible party prior to initiate antianxiety medication for Resident 7. 2. A review of Resident 10's clinical record indicated the resident admitted to the facility on 1/4/11 with diagnoses including schizophrenia, and dementia (is the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning. The resident has a public conservator for his care and his estate. According to the MDS, dated 1/17/14, Resident 10 had cognitive impair, and required extensive assistance to total dependence on staff for dressing, toilet use and personal hygiene. A review of the physician's order, dated 1/8/14, indicated to administer Haldol (antipsychotic) 1.5	F 154	reviews. Audit results will be given to the DON for immediate corrective actions as needed. MONITORING EFFECTIVENESS The DON will present the results of the audits to the Quality Assurance (QA) Committee on a quarterly basis to ensure continued compliance.	

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F 154	Continued From page 3 milligrams (mg) by mouth (PO) at bedtime (QHS). A review of the Consent to the administration of psychoactive medication indicated the informed consent was not obtained from the resident's public guardian prior to initiate antipsychotic medication for Resident 10. During an interview with the Director of Nurse (DON) on 2/22/14 at 2:30 p.m., she stated Resident 10's public conservator visits the residents every three months, and Resident 7's niece is available via telephone. The DON was unable to explain why Resident 7's and Resident 10's physicians did not explain the risk and benefit regarding antianxiety and antipsychotic medication to the residents' public conservators and the responsible party prior to initiate the therapy.	F 154		
F 176 SS=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 failed to have the Interdisciplinary Team (IDT) assess the resident for self medication administration for one of 11 sampled residents (11). For Resident 11, the facility failed to have the physician assess, and determine it is safe for the	F 176	**F176 – It is the policy of this facility that an individual may self-administer drugs if the interdisciplinary team has determined that this practice is safe.** **CORRECTIVE ACTION** The interdisciplinary team (IDT) reassessed Resident 11's ability to self-administer medications and due to the decline of his vision, it was determined that Resident 11 could no longer safely self-administer his medications. Resident 11 agreed to check in and leave any over-the-counter medications he brings into the facility with the licensed nurses at the nursing station. In addition, a licensed nurse removed the eye drop medications and Pepto Bismol	3/5/14

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F 176	Continued From page 4 resident to self administer his eye drops medication. This failure had the potential to result in unsafe self medication administration, and ineffective treatment. Finding: A review of of Resident 11's medical record indicated the resident admitted to the facility on 6/4/10 with diagnoses including glaucoma (is a complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss) and legally blind. According to the Minimum Data Set (MDS-Resident Assessment and Care Screening Tool) dated 12/17/13 indicated Resident 11 had cognitive intact, required limited assistance to extensive assistance from staff for all activities of daily living (ADLs). During an observation on 2/20/14 at 6:30 p.m., in Resident 11's room, the resident's bedside table had: 1. A bottle of Dorzolaminde Hcl 2% (eye drops medication used to treat ocular hypertension (a condition where the pressure inside the eye is higher than normal) and open angle glaucoma (eye disease that can cause blindness when left untreated)]. 2. A bottle of Alphagan 0.15% eye drops (medication used to treat open-angle glaucoma). 3. One bottle of pepto bismol (an over the counter medication that provides relief from diarrhea and upset stomach). 4. One bottle of Iodine 10% solution	F 176	from Resident 11's bedside on 2/20/14 and stored them in the medication cart. The expired Iodine 10% solution was immediately discarded by the licensed nurse on 2/20/14. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents who self-administer medications were at risk due to this deficient practice; there are no additional residents who self-administer medications at this time. The interdisciplinary team (IDT) coordinator will ensure that all able and willing residents that want to self-administer medications are assessed by all members of the IDT upon admission. Once approved by the IDT and all signatures are obtained, the licensed nurse will be responsible for initiating an individualized care plan for the self-administration of medications and will monitor the resident accordingly. **SYSTEMIC CHANGES** The DSD gave an in-service to all licensed nurses on 3/5/14 regarding the facility's medication self-administration policy. **MONITORING EFFECTIVENESS** The DON will continue to monitor the ability of any resident who is able to self-administer medications and review with IDT members before approval. DON will report quarterly to the QA Committee if any resident's condition declines and is no longer able to self-administer. QA Committee will review DON's reports	

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F 176	Continued From page 5 (Highly-effective topical preparation kills susceptible bacteria, fungi, protozoa, yeast and viruses). The bottle had an expiration dated of 10/2013. A review of the physician recapitulation orders for the month of February, 2014 indicated to administer Alphagan 0.15% one drop (GTT) both eyes (OU) three times a day (TID), and Truscopt (Dorzolamide Hcl) 2% one GTT OU twice a day (BID). During an interview with Resident 11 on 2/20/14 at 6:45 p.m., regarding the medication at the bedside table, he stated "I can not see, can you help me?". The resident continued to state the eye drops medication with the green cap is to be administer three time a day, and the other eye drops medication is to be administer one time a day. When asked why the two eye drops medication at his bedside table with two orange caps, the resident stated he lost the green cap and the staff replaced it with the same color with the other cap. During an observation on 2/20/14 at 6: 55, the Licensed Vocational Nurse (LVN 3) took all medication on Resident 11's bedside table including the two bottles of eye drops. During an interview with the Director of Nurses (DON) at 7:00 p.m., she stated Resident 11 had medication at the bedside because he administer medication by himself. During an observation on 2/20/4 at 7:25 p.m., Resident 11 was observed asking LVN 3 to give him his eye drops. Resident 11 stated "Where is my eye drops? I need the one three time a day". LVN 3 stated "I will give it to you at bedtime".	F 176	quarterly in order to remain in compliance.	

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F 176	Continued From page 6 Resident 11 continued to state "No, no, I need it now, I did not have any all day today". A review of the IDT of self-administration of medication, dated 7/25/13, indicated the physician's signature to determine Resident 11 is able to carry out self-administration of medication safely and responsibly was missing. During an interview with the DON on 2/22/14 at 2:50 p.m., she provided no explanation on how an legally blind resident able to administer his own eye drops when he can not differentiate the deference between the eye drops, and why the physician did not signed the IDT assessment of self-medication administration of medication. A review of Resident 11's care plan indicated there was no care plan for self medication administration, and no documentation indicated how the staff teach the resident regarding self-medication administration.	F 176		
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 failed to ensure one of randomly selected resident (RSR 12) was	F 246	**F246 – It is the policy of this facility to ensure that 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.** **CORRECTIVE ACTION** The height of the dining table was immediately adjusted for Resident 12 on 2/22/14. Licensed Vocational Nurse (LVN) 1 was also counseled	2/28/14

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F 246	Continued From page 7 properly positioned for comfort during dinner. RSR 12 was observed eating dinner in the dining room with the table positioned too high for the resident, causing the resident to reach up in order to obtain the food and drinks. This deficient practice may result in an unpleasant dining experience, frustration, fatigue and inadequate food intake for the resident. Findings: On 2/21/14 at 5:50 p.m., during dining observation, RSR 12 was observed awake, eating dinner, sitting on her wheelchair in the lowest height position, with the table positioned across the resident which was too high and at the level of the resident's face. RSR 12 was observed having difficulty reaching up to obtain her food and some food items were out of the resident's reach. A review of RSR 12 's clinical record indicated the resident was readmitted to the facility on 6/8/12 with diagnoses that included hypertension, diabetes mellitus, anemia, and depression. The quarterly Minimum Data Set (MDS - standardized assessment and care planning tool) dated 10/3/13, indicated RSR 12 had no short-term and long-term memory problems, was independent in cognitive skills for daily decision-making, and needed supervision (oversight, encouragement or cueing) with eating. On 2/21/14 at 5:55 p.m., during an interview, Licensed Vocational Nurse 1 (LVN 1), stated the	F 246	by the DON on 2/22/14 regarding the facility's policy on dignity. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The Director of Staff Development (DSD) made rounds on 2/22/14 to ensure that the table heights were adjusted accordingly for all residents in the dining room as well as for residents who choose to eat in their own rooms. **SYSTEMIC CHANGES** The DSD gave an in-service to all nurses on 2/28/14 regarding dignity. All licensed nurses will also perform rounds during meal times to ensure that residents are comfortable and treated with dignity while eating. **MONITORING EFFECTIVENESS** The DSD will present the findings of this system to the QA committee for review quarterly and to evaluate its effectiveness.	

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F 246	Continued From page 8 height of the bedside table must be adjusted to the resident's height for the resident to be able to easily reach and see her food in order to have adequate food intake. At 6 p.m., during an interview, Director of Nursing (DON) stated the bedside table must be lowered for RSR 12 to easily reach her food and to provide a pleasant dining experience, avoid frustration and fatigue. According to the facility's undated policy and procedure titled, "Serving Food" indicated to assist patient to a comfortable position for mealtime.	F 246		
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 monitor the weight and vital signs pre (before) and post (after) hemodialysis (medical procedure using a machine to remove toxic substances or metabolic wastes from the bloodstream) for one of 11 sample residents (1) in accordance with the plan of care and facility's policy.	F 309	**F309 – It is the policy of this facility to ensure that each resident receives and the facility provides 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.** **CORRECTIVE ACTION** The DON gave an in-service to all licensed nurses on 2/26/14 regarding documentation, specifying the completion of pre and post-dialysis assessments. Upon a dialysis resident's return from the dialysis center, the licensed nurse on duty is responsible for obtaining the pre and post-dialysis statistics (vital signs, weight, etc.) from the dialysis center if blank upon resident's return to the facility.	2/26/14

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F 309	Continued From page 9 Resident 1's pre and post hemodialysis weight and vital signs were not monitored on 1/17/14 and on 2/14/14. This deficient practice had the potential for fluid over/under load complications secondary to dialysis treatment. Findings: On 2/20/14 at 7:05 p.m., during the initial tour of the facility, escorted by director of nursing (DON), Resident 1 was observed awake, lying in bed with an intact arteriovenous (AV) shunt (a surgically created connection between an artery and a vein to provide vascular access for hemodialysis) site on the right upper arm area. A review of the clinical record indicated Resident 1 was readmitted to the facility on 7/15/09 with diagnoses that included end stage renal disease (ESRD), angina (a condition in which a spasmodic attacks of suffocating pain occurs), diabetes mellitus, and hypertension (high blood pressure). The quarterly Minimum Data Set (MDS), an assessment and care screening tool, dated 1/28/14, indicated Resident 1 had no memory problems, was independent in cognitive skills for daily decision making, and required extensive assistance (weight bearing support and at times requires full staff performance) from staff for activities of daily living (ADLs). A review of the physician's order dated 1/2/14, indicated Resident 1 for dialysis at a dialysis center on Mondays, Wednesdays, and Fridays.	F 309	IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION All residents on dialysis were at risk of being affected by this deficient practice. The DON notified the dialysis center on 2/24/14 about incomplete documentation of the nursing staff at the dialysis center. The DON explained that the dialysis center is to provide this information to the nursing facility in order for the resident to have continuity of care. SYSTEMIC CHANGES The MRD will perform monthly audits of the Dialysis Assessments binder to ensure that pre and post-dialysis documentation is complete and done timely. The results of the audit will be given to the DON for review upon completion every month. MONITORING EFFECTIVENESS The DON will present the results of the MRD's audit to the QA committee on a quarterly basis to ensure continued compliance.	

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F 309	Continued From page 10 A review of the Dialysis Record dated 1/17/14 and 2/14/14 were incomplete. There were no documented evidence of pre and post dialysis vital signs being monitored in the dialysis center on 1/14/14, and there were no documented evidence of pre and post dialysis weight and vital signs being monitored in the dialysis center on 2/14/14. A plan of care dated 2/22/14 developed for Resident 1's risk for health complications due to dialysis, and risk for bleeding at shunt site, with the approaches or plan to monitor weight pre and post, diet and medications as ordered. On 2/22/14 at 2:30 p.m., during an interview, DON stated the licensed nurses were expected to perform pre and post dialysis assessment and monitoring of pre and post dialysis weight and vital signs to ensure a complete assessment of the resident to prevent complications from dialysis treatment. At 3 p.m., during an interview, licensed vocational nurse 2 (LVN 2) stated the pre and post dialysis weight and vital signs from the dialysis center should be documented in the Dialysis Record for monitoring to prevent complications from fluid and electrolyte imbalance. According to the facility's undated policy and procedure titled "Care of the Dialysis Resident," indicated the purpose of preventing complications such as fluid overload, infection or clotting of the access area, or hemorrhage in the dialysis resident. The policy further indicated pre and post dialysis weight will be monitored (should be weighed at the dialysis unit).	F 309		
F 322	483.25(g)(2) NG TREATMENT/SERVICES -	F 322		

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F 322 SS=D	Continued From page 11 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 (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 that the head of the bed of a resident receiving gastric tube feeding (GT feeding - feeding given through a tube that has been surgically inserted into the stomach to provide nutrition) was elevated at a 30 degree angle while feeding was infusing for one of 11 sampled residents (Resident 4) in accordance with the plan of care. This deficient practice had the potential to cause aspiration (food goes into the lungs or airways), nausea, vomiting, and tube feeding	F 322	**F322 – It is the policy of this facility to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers to restore, if possible, normal eating skills.** **CORRECTIVE ACTION** The LVN immediately elevated the head of Resident 4's bed on 2/21/14. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents receiving tube feedings were at risk due to this deficient practice. On 2/21/14, the DSD and licensed nurses checked the beds of all residents receiving tube feedings to ensure that the heads of their beds were elevated 30-45 degrees in order to prevent aspiration; no additional residents were found to have been affected by this deficient practice. **SYSTEMIC CHANGES** The DSD gave an in-service to all nursing staff on 2/24/14 regarding elevating the heads of beds (HOB) at 30-45 degree angles for all residents receiving tube feedings. During their rounds, all licensed nurses will ensure that the HOBs are elevated to a 30-45 degree angle for those residents receiving enteral feedings. The DON and DSD will monitor the compliance of all nursing staff to proper bed positioning during	2/24/14

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F 322	Continued From page 12 complications. Findings: On 2/21/14 at 5:25 p.m. and 7:25 p.m., during rounds with Licensed Vocational Nurse 1 (LVN 1), Resident 4 was observed awake in bed, with the head of the bed raised at approximately 15 to 20 degree angle with GT feeding of HN 2 Cal (formula) infusing at 60 cubic centimeters (cc) per hour. During the time of observations, LVN 1 immediately elevated the resident's head of bed (HOB) to 30 degree angle. A review of the clinical record indicated Resident 4 was admitted to the facility on 2/15/14 with diagnoses that included dysphagia (difficulty in swallowing), hypertension, and malnutrition. The "Nurses' Admission Record" dated 2/15/14, indicated that Resident 4 was awake, non verbal, but responsive to painful stimuli, and required extensive assistance (weight bearing support and at times requires full staff performance) to total dependence (full staff performance every time during entire 7 day period) from staff for activities of daily living (ADLs). The physician's order dated 2/15/14 indicated to give HN 2 Cal (formula) infusing at 60 cc per hour for 22 hours via GT feeding. The order further indicated to keep HOB elevated at all times during feeding. A plan of care dated 2/22/14 developed to address the care of the resident with a tube feeding related to dysphagia, had a goal not to exhibit signs and symptoms of aspiration daily. The approaches included to maintain HOB	F 322	daily clinical rounds. MONITORING EFFECTIVENESS The DON will report the results of the bed positioning monitoring to the QA committee quarterly for suggestions on continued compliance.	

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F 322	Continued From page 13 elevation of 30 to 45 degrees during enteral feedings. On 2/22/14 at 3 p.m., during an interview, LVN 2 stated that Resident 4's head of bed should be elevated 30 to 45 degree angle at all times to prevent aspiration, nausea, vomiting, and gastric tube feeding complications. At 3:15 p.m., during an interview, certified nurse assistant (CNA) stated all resident's head of bed should be elevated to at least 30 degree angle at all times while GT feeding is infusing to prevent tube feeding complications. The facility's undated policy and procedure titled, "Enteral Tube Feeding," indicated to elevate the head of the bed to at least 30 degrees as ordered, check placement of feeding tube every eight hours or more often as needed, and to check mouth/throat of unconscious patients for coiled tubing.	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 and interview, the facility failed to secure television (TV) sets placed on top	F 323	**F323 – It is the policy of this facility to 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.** CORRECTIVE ACTION The Maintenance Supervisor (MS) and his designated staff secured the television sets in 13 resident rooms using safety straps on 3/14/14.	3/14/14

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F 323	Continued From page 14 of residents' dressers, night stands and tables in 13 of 29 rooms. This deficient practice had the potential to cause severe injuries in the event of an accidental fall. Findings: On 2/21/14 and 2/22/14, during the general observation of the facility's interior environment, in the presence of the maintenance supervisor, the facility failed to secure residents' TV sets in Rooms 1, 3, 4, 5, 6, 7, 8, 10, 14, 16, 18, 21, 23 and 26. The TV sets were observed placed on top of residents' dressers, night stands and tables were not secured. The appliances were easily moved when touched. During an interview on the 2/22/14, at 2:40 p.m., the maintenance supervisor stated the TV sets would be secured for the safety of the residents, staff, and visitors.	F 323	<u>IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION</u> The safety of all residents with unsecured television sets were at risk due to this deficient practice. No additional television sets were found to have been unsecured when the MS checked all television sets on 3/14/14. <u>SYSTEMIC CHANGES</u> The Administrator counseled the MS on 2/24/14 to monitor all television sets during his daily rounds. The Social Services Designee (SSD) and all nursing staff will utilize the maintenance service log to notify the MS of proposed room changes and/or new admissions to ensure that television sets involved get secured as soon as possible. <u>MONITORING EFFECTIVENESS</u> The MS will include the securing of all television sets in his monthly safety report and will also be reviewed by the QA committee on a quarterly basis to ensure that this corrective action is monitored, achieved, sustained and evaluated for its effectiveness.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	**F329 – It is the policy of this facility to ensure that each resident's drug regimen is free from unnecessary drugs.** <u>CORRECTIVE ACTION</u>	3/15/14

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F 329	Continued From page 15 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents, who are on Ativan (antianxiety) had proper diagnosis, indication, specific manifestation, provided with adequate monitoring, assessed for causative factors and attempted non-pharmacological interventions (other alternative measures other than medicine) for one of 11 sampled residents (Resident 7). For Resident 7, the facility failed to ensure the resident had an indication for the use of Ativan. This deficient practice had the potential to result in unnecessary psychoactive medication management, placing the residents at risk for potential side effects of the medication. Findings: 1 A review of Resident 7's clinical record indicated the resident admitted to the facility on 4/9/10 with diagnoses including schizophrenia (a	F 329	On 3/15/14, a licensed nurse notified Resident 7's physician regarding the resident's use of Ativan without a specific indication; the physician discontinued the Ativan on 3/15/14. The licensed nurses will assess Resident 7 for any causative factors of her behaviors and will attempt non-pharmacological interventions as needed. IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION All residents receiving psychoactive medications without an indication for its use are at risk due to this deficient practice. The DON and licensed nurses reviewed the medical records of all residents receiving psychoactive medications to ensure that each medication had an indication for its use; no additional residents were affected by this deficient practice. The DSD gave an in-service to all licensed nurses on 3/10/14 regarding psychoactive medications, emphasizing that each medication shall have proper diagnosis, indication, specific manifestation and adequate monitoring. SYSTEMIC CHANGES The MRD will conduct monthly psychoactive audits to ensure that all psychoactive medications have an indication for its use and are being monitored for episodes of behavior. The results of these monthly audits will be given to the DON for review and follow-up as needed. MONITORING EFFECTIVENESS	

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F 329	Continued From page 16 disorder characterized by a breakdown in thinking and poor emotional responses) and hypertension (high blood pressure). The resident had a niece as the responsible party. According to the Minimum Data Set (MDS-Resident Assessment and Care Screening Tool) dated 1/22/14 indicated Resident 7 had cognitive impair, and required total dependence on staff for transferring, dressing, toilet use and personal hygiene. A review of the physician's order, dated 8/26/13, indicated to administer Ativan (Lorazepam-an antianxiety medication) 0.5 milligrams (mg) by mouth (PO) at bedtime (QHS). A review of the undated psychotropic summary sheet for the used of Ativan 0.5 mg for hallucinating that other will harm her dated 2/1/12 to 10/31/14 (almost 2 years) indicated the resident had no behavior episodes of hallucination (sensations that appear real but are created by your mind). During an observation on 2/22/14 at 9:30 a.m. , Resident 7 was lying in bed talking to herself and constantly moving her hands. During an interview with LVN 3 on 2/22/13 at 1:55 p.m., regarding why Resident 7 receives Ativan everyday, LVN 3 stated the resident's niece request for the resident to receive Ativan at night so the medication can calm the resident down. During an interview on 2/22/14 at 2:00 p.m. , the Certified Nurse Assistant (CNA 1) stated Resident 7 likes to talk a lot, and sometimes refused care. CNA 2 further state the resident did not have	F 329	The DON will present the results of these audits to the QA committee quarterly to evaluate its effectiveness and for suggestions on continued compliance.	

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F 329	Continued From page 17 behavioral problem such as yelling and hitting others beside talking to herself. During an interview with the DON on 2/22/14 at 2:10 p.m., she unable to explained why Resident 7 is taking Ativan daily for almost two years.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure food was stored, distributed and served under sanitary conditions by having no dates or labels identifying foods stored in the kitchen reach-in refrigerators; by having inadequate freezer temperature; failing to ensure the interior of the kitchen reach-in freezer was in proper repair condition and the exterior was maintained clean and sanitary; by maintaining the kitchen hood and can opener clean and sanitary. This deficient practice had the potential for cross contamination and foodborne illness. Findings:	F 371	**F371 – It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.** **CORRECTIVE ACTION** 1a. on 2/22/14, the Dietary Services Supervisor (DSS) immediately discarded the unlabelled eggs, bologna, cheese and peanut butter and jelly sandwiches that were in the kitchen refrigerator. 1b. The DSS immediately discarded the unlabelled fat free and reduced fat milk on 2/22/14. 1c. The DSS immediately adjusted the freezer temperature gauge on 2/22/14 in order to maintain a freezing temperature of 0 degrees Fahrenheit or below. 2. The MS replaced the torn rubber gasket and	2/23/14

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F 371	Continued From page 18 On 2/22/14, at 6:15 p.m., during the initial inspection of the kitchen in the presence of the assistant dietary service supervisor (ADSS), the following was observed: 1.(a). There was missing label and dates egg, bologna and cheese, peanut butter and jelly sandwiches stored inside the kitchen reach-in refrigerator. (b). There was missing labels on left-over half gallon Alta Dena fat free and reduced fat milk stored on reach-in refrigerator shelf. (c). The temperature of the kitchen reach-in freezer and a 4 oz. vanilla cup ice cream were observed at 20 degrees Fahrenheit. The thermometer was left in the freezer for 45 minutes to confirm the freezer temperature at the time of observation. 2. The rubber gasket and plastic panel inside the kitchen reach-in freezer was broken and duck tape was used to hold loose parts together. The exterior of the freezer have a significant amount of dust and debris in and around the cooling system. 3. There was a significant amount of dried food residue on and around the kitchen can opener blade. 4. There was accumulation of grease and dust under the kitchen hood. 5. There was missing light cover on florescent light bulbs above he kitchen food preparation table neat the steam table. A review of the facility's policy and procedure on Storage of Frozen and Refrigerated food items indicated that freezer temperature must be maintained in at 0 degrees Fahrenheit or below. And all refrigerated food and left-over food items	F 371	plastic panel inside of the kitchen reach-in freezer on 2/24/14. The exterior of the freezer was cleaned by the dietary staff on 2/22/14 and the dust and debris were removed. 3. A dietary aide cleaned the kitchen can opener blade on 2/22/14 to remove the dried food residue. 4. Dietary staff removed the grease and dust under the kitchen hood on 2/22/14. 5. The MS replaced the light cover above the kitchen food preparation table near the steam table on 2/22/14. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of all residents and staff were at risk due to these deficient practices. The MS gave an in-service to all dietary staff on 2/28/14 regarding interior maintenance of the kitchen. All defective equipment will be logged in the maintenance log book for proper follow-up. **SYSTEMIC CHANGES** The MS and DSS will visually inspect the kitchen during their daily rounds to ensure that all equipment and cleanliness are maintained on a continual basis. The results of any repairs and daily visual inspections will be discussed by the DSS and MS during the monthly safety meetings.	

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F 371	Continued From page 19 must be labeled and dated. In an interview on 2/22/14, at 12:30 p.m., the dietary service supervisor stated the deficiencies will immediately be corrected.	F 371	Dietary Supervisor has been counseled by the Administrator regarding labeling and dating all refrigerated food and leftover food items MONITORING EFFECTIVENESS The MS will present topics discussed at the monthly safety meetings as well as repairs made within the facility to the QA committee for suggestions on continued compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the pharmacist review each resident's medication regimen, and an annual dose reduction attempt for Thorazine (antipsychotic medication) for one of 11 sampled residents (Resident 5). For Resident 5, the facility failed to attempt a gradual dose reduction or document why a dose reduction is contraindicated while the resident is taking Thorazine for for more than a year. This failure had the potential for serious irreversible adverse effects on the resident caused by the medications.	F 428	**F428 – It is the policy of this facility to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.** CORRECTIVE ACTION Resident 5 was assessed by a licensed nurse on 2/24/14 regarding Resident 5's use of Thorazine. The licensed nurse notified Resident 5's physician and the medication was unchanged due to resident's stable condition. Care plans were reviewed and revised on 2/24/14 to reflect the updated physician's orders. Resident 5's Thorazine was discontinued on 4/15/14. IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION	3/10/14

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F 428	Continued From page 20 Findings: During an observation on 2/22/14 at 11 a.m., Resident 5 was sitting in a wheelchair, the resident's CNA at his side helped with care. A review of Resident 5's clinical record indicated the resident admitted to the facility on 5/23/11 with diagnoses including schizophrenia (mental disorder characterized by a breakdown in thinking and poor emotional responses) and Dementia (is the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning). According to the Minimum Data Set (MDS-Resident Assessment and Care Screening Tool) dated 11/23/13 indicated Resident 5 had cognitive impaired in daily decision making, totally dependent on staff for all activities of daily living, and is incontinent of both bowel and bladder functions. A review of the physician's order dated 4/30/13 indicated Resident 5 is taking Thorazine (Chlorpromazine HCL) 200 milligram (MG) via gastrostomy tube (GT) twice a day (BID). A review of Resident 5's drug regiment review from October, 2013 to January, 2014 indicated there was no drug regimen review conducted by the pharmacist for the use of Thorazine. There was no documentation indicated the gradual dose reduction was contraindicated for the use of Thozarize.	F 428	All residents receiving psychoactive medications were at risk due to this deficient practice. Licensed nurses will maintain a list of all residents receiving psychoactive medications as well as when these medications were started and provide the list to the DON for review on a monthly basis. The Pharmacy Consultant will use this list during his monthly drug regimen review for possible gradual dose reductions and will notify the attending physician and DON of his recommendations for follow-up. SYSTEMIC CHANGES The Pharmacy Consultant gave an in-service to all licensed nurses on 3/10/14 regarding gradual dose reductions and the importance of individualized assessments based on behavioral symptoms to avoid unnecessary drugs. The DON will maintain a list of residents on psychoactive drugs to monitor gradual dose reductions made, if any, each month. All residents who are on psychoactive medications have been reviewed every six months and have received gradual dose reductions. MONITORING EFFECTIVENESS The DON will present her list of current residents on psychoactive medications with dates of gradual dose reductions made to the QA committee on a quarterly basis to ensure continued compliance.	

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F 428	Continued From page 21 During an interview with the DON on 2/21/14 at 7:30 p.m., she stated there was no attempt drug reduction for the use of Thorazine since 1/28/13. During an interview with Resident 5's CNA (CNA 2) On 2/22/14 at 11:15 a.m., she stated the resident is quiet, but able to follow direction from staff. CNA 2 further stated, she has been taking care of the resident for more than a year and she did not witness the resident have any behavior such as yelling or hitting himself or others.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	**F431 – It is the policy of this facility to ensure that drugs and biologicals used in the facility are 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.** **CORRECTIVE ACTION** 1. The expired bottle of Iodine 10% solution was immediately removed from Resident 11's bedside on 2/20/14 by a licensed nurse and was discarded.	2/28/14

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(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 431	Continued From page 22 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 properly dispose of expired medications, and keep the medication in an secure area for one of 11 sampled Residents (Resident 11). For Resident 11, the facility failed to keep the medication in the medication room. This deficient practice had the potential to result in medication errors and medication diversions. Findings: During an observation on 2/20/14 at 6:30 p.m., Resident 11's bedside table had: 1. One bottle of Iodine 10% solution (Highly-effective topical preparation kills susceptible bacteria, fungi, protozoa, yeast and viruses). The bottle had an expiration dated of 10/2013. 2. One bottle of pepto bismol (an over the counter medication that provides relief from diarrhea and upset stomach).	F 431	2. A licensed nurse removed the bottle of pepto bismol from Resident 11's bedside on 2/20/14 and stored it in the locked medication cart. 3. A licensed nurse removed the bottle of Dorzolaminde Hcl 2% from Resident 11's bedside and stored it in the locked medication cart. 4. A licensed nurse removed the bottle of Alphagan 0.15% from Resident 11's nedside and stored it in the locked medication cart. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** All residents with medications at the bedside were at risk due to this deficient practice. Licensed nurses checked the bedsides of all residents in the facility on 2/20/14 and no additional residents were found to have medications at the bedside. **SYSTEMIC CHANGES** The DSD gave an in-service to all nursing staff on 2/28/14 regarding the facility's policy on medication storage, with emphasis that any medication shall only be accessible to authorized individuals. Licensed nurses will conduct visual inspections during medication administration rounds to ensure that the facility's policy is adhered to daily. Any unauthorized medication found at the bedside of a resident	

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F 431	Continued From page 23 3. A bottle of Dorzolaminde Hcl 2% (eye drops that used to treat ocular hypertension (condition where the pressure inside the eye is higher than normal) and open angle (eye disease that can cause blindness if it is left untreated)]. 4. A bottle of Alphagan 0.15% (eye drops that used to treat open-angle glaucoma). During the interview with the Licensed Vocational Nurse (LVN 3) on 2/20/14 at 6:55 p.m., she stated the Iodine bottle was expired on 10/2013. LVN 3 stated the expired Iodine solution was used to clean Resident 11's AV shunt (A fistula used for hemodialysis is a direct connection of an artery to a vein). During an interview with the DON on 2/20/24 at 7:00 a.m., she stated expired medications and non-medication related items should not be store at the resident's bedside table. A review of the facility's undated policy for storage of medications indicated the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures and immediately removed from stock, disposed or according to procedures for medication disposal and reordered from the pharmacy, if a current order exists. The policy also indicated for residents who self-administer medications, the following conditions are met for bedside storage to occur: a The manner of storage prevent access by other	F 431	will immediately be confiscated and the DON and Administrator will be notified. MONITORING EFFECTIVENESS The DON will present any findings of unauthorized medications at the bedside to the QA committee on a quarterly basis for suggestions on continued compliance.	

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F 431	Continued From page 24 residents. Lockable drawers or cabinets are required only if unlocked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy or in the original container if a nonprescription medication. c. The bedside medication record is reviewed, and the administration information is transferred to the Medication Administration Record (MAR) kept at the nursing station. Notation of self-administered dose is made by placing a check mark in the appropriate space and noting in the nursing comments the initials of the nurse who obtained the information from the resident.	F 431		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain essential mechanical equipment in a safe operating condition for the laundry dryer. The dryer had a torn lint filter screen measuring 11-inches on the laundry lint filter. Torn and/or loose lint filter had the potential to cause lint to escape into the hot chamber of the dryer posing a fire risk. Findings: On 2/22/14 at 3:30 p.m., during the tour of the laundry room, in the presence of the maintenance supervisor, there was a torn lint filter screen	F 456	**F456 – It is the policy of this facility to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.** **CORRECTIVE ACTION** The torn lint filter screen on the laundry dryer was removed and replaced with a new one by the MS on 2/23/14. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** The safety of everyone in the facility was at risk due to this deficient practice. The MS gave an in-service to all laundry personnel on 2/24/14	2/24/14

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F 456	Continued From page 25 measuring 11-inches on the laundry lint filter dryer. On the same date at 3:40 p.m., during an interview, the maintenance supervisor stated the facility will repair or replace the defective lint filter.	F 456	regarding general maintenance issues in the laundry room. He also mentioned that the maintenance log book is in place for items needing replacement or repair. **SYSTEMIC CHANGES** The MS will inspect the laundry room along with the Laundry Supervisor on a daily basis during morning rounds. The results of the morning rounds will be given to the Administrator on a weekly basis or more immediately as needed. **MONITORING EFFECTIVENESS** The MS will report the findings of his daily rounds as well as any repairs/replacements made to the Safety committee during their monthly meetings. The MS will also present the same findings to the QA committee on a quarterly basis to ensure continued compliance.	
F 504 SS=E	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure medically necessary laboratory services were provided as ordered by the physician for two of 11 sampled residents (5 and 6). For Resident 5, the facility failed to obtain monthly Depakene level as the physician ordered. For Resident 6, the facility failed to obtain hgbA1C (an important blood test used to determine how well the diabetes is being controlled, the test provides an average of the blood sugar control over a six to 12 weeks period) every three months as the physician ordered. This deficient practice placed the resident at risk for complication due to unmonitored lab works. Findings: 1. A review of Resident 5's clinical record	F 504	**F504 – It is the policy of this facility to provide or obtain laboratory services only when ordered by the attending physician.** **CORRECTIVE ACTION** The depakene level for Resident 5 was promptly ordered by a licensed nurse on 2/24/14. The hgbA1C was also ordered on 2/27/14 by the same licensed nurse. Both labs were then added to the routine lab book by a licensed nurse. The DON gave one-to-one counseling to each licensed nurse who failed to include these	2/27/14

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F 504	Continued From page 26 indicated the resident was admitted to the facility on 5/23/11 with diagnoses including schizophrenia (mental disorder characterized by a breakdown in thinking and poor emotional responses) and Dementia (is the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning). According to the Minimum Data Set (MDS-Resident Assessment and Care Screening Tool) dated 11/23/13 indicated Resident 5 had cognitive impair in daily decision making, totally dependent on staff for all activities of daily living, and is incontinent of both bowel and bladder functions. A review of the physician's order dated 4/30/13 indicated Resident 5 is taking Depakene (Valproate Sodium) 500 milligram per 10 milliliter (mg/ml) via gastrostomy tube (GT) twice a day (BID). The physician order dated 2/28/13 stipulated to monitor Depakene serum level monthly. A review of the laboratories report from October, 2013 to January, 2014 indicated there were no Depakene level available to be review. During an interview with the Director of Nurses (DON) on 2/21/14 at 7:10 p.m., she stated the facility staff did not make sure the Depakene level was drawn as the physician's order. The DON had no explanation on why the Depakene level had not been done. 2. A review of Resident 6's clinical record	F 504	labs in the routine lab book. IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION The DON in-serviced all licensed nurses on 2/26/14 regarding the carrying out of physician's orders, particularly laboratory orders. The DON and designate licensed nurses cross-checked all physician's orders on 2/26/14 for laboratory work against the routine laboratory book to ensure that all laboratory orders are accounted for. SYSTEMIC CHANGES The MRD will audit all resident medical records for routine laboratory orders on a monthly basis and will notify the DON of her findings to ensure that routine laboratory orders are scheduled accordingly. MONITORING EFFECTIVENESS The MRD will report the results of her routine laboratory audit to the DON monthly. The DON will in turn report the compliance of all licensed nurses in ordering routine laboratory orders to the QA committee on a quarterly basis to ensure continued compliance and to evaluate effectiveness.	

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F 504	Continued From page 27 indicated the resident admitted to the facility on 4/11/12 with diagnoses including diabetes mellitus (is a condition characterized by high blood glucose (sugar) levels due low insulin) and diabetes mellitus coma [When there is not enough insulin, the body cannot use glucose for energy, fat is broken down and then converted to ketones in the liver. The ketones can build up excessively when insulin levels remain too low. This type of coma is triggered by the build-up of chemicals called ketones (Ketones are strongly acidic and cause the blood to become too acidic)] According to the Minimum Data Set (MDS-Resident Assessment and Care Screening Tool) dated 1/13/14 indicated Resident 6 had cognitive impair in daily decision making, totally dependent on staff for bed mobility, transfer, dressing, personal hygiene, and incontinent of both bowel and bladder functions. A review of the physician's recapitulation order for the month of February 2014 indicated Resident 6 is receiving Lantus (insulin) 15 unites subcutaneous (SQ) daily for her diabetes. The physician order dated 7/17/12 stipulated to monitor hgb A1C level every three months. A review of the laboratories report from July, 2013 to January, 2014 indicated there were no Hgb A1C level available to be review. During an interview with the DON on 2/22/14 at 9:45 a.m., she stated her staff did not obtained the Hgb A1C level as the physician ordered. The DON stated she thought her nurses would make sure to carry out the physician orders.	F 504		

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F 504	Continued From page 28 A review of the facility's undated policy and procedure titled "Lab Work" indicated the facility need to ensure that lab tests are performed per physician's order.	F 504		