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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. BUILDING ______ B. WING ______	01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1260 TRAVIS BLVD FAIRFIELD, CA 94533

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey on 1/13/14 to 1/17/14. Census on the date of Entry was 64 Residents with one bed hold. Representing the California Department of Public Health were Surveyors 29092, 31424 and 33028 Health Facility Evaluator Nurses. A Federal complaint investigation was done with Intake # CA00382821. The findings of the investigation regarding the complaint was unsubstantiated.	F 000	This Plan of Correction (POC) serves as our written credible allegation of compliance for the deficiencies noted during the recertification survey on 1/13/14 to 1/17/14 but subject to our request for the deletion of F 364 and F 361 via IDR submitted ahead of this POC on 2/17/14.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure a randomly reviewed resident (Resident 16) was be free from physical restraint, with the potential for decreased physical capability and the further deterioration of her muscle tone. Findings: During a tour of the facility on 1/17/14 at 8:20 a.m. Resident 16 was observed using a lap tray	F 221	F 221 1. Resident 16 is no longer in the facility. However, the Administrator reviewed the problem identified for Resident 16 with the DON. 2. The DON reviewed the medical records of all residents on physical restraints to ensure that no other resident is affected by the problem found for Resident 16. 3. The Administrator in-serviced the DON on the must of consistently completing an initial assessment prior to the application of physical restraint and quarterly assessment or as often as needed to evaluate the appropriateness of continuing with the restraint being applied.	 1/20/14 1/31/14 2/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 3-18-14

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.

Received and accepted the Plan of Correction from Raul [illegible] - Administrator on 3/18/14 at 3:20PM [illegible] HFEN [illegible]

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F 221	Continued From page 1 attached to her wheelchair while seated in front of the Nurses' station. The wheelchair's foot rest was also attached and and the front of the foot rest was inclined upward where Resident's 16 feet were resting. During an interview on 1/17/14 at 8:20 a.m., Resident 16 stated that she could not remove her lap tray. A resident seated beside her, who was alert and oriented, stated that Resident 16 had a lap tray to prevent her from standing up. During an interview on 1/17/14 at 8:30 a.m., Management Staff A stated that the lap tray was placed for positioning because "[Resident's name] head was always going down and to prevent her from standing up." Record review, on 1/17/14, of Resident 16 MDS (minimum data set, an assessment tool) dated 11/15/13, indicated that her cognitive skills for activity of daily living were severely impaired and supervision was needed. Record review further indicated that no evaluation was done before the use of the lap tray. Review of the facility policy and procedure for the use of physical restraints on 1/17/14 dated 7/12 indicated that ...."It is the policy of the facility that if the restraint is needed it has to indicate a medical necessity due to resident physical condition." Procedure indicated that ...Reevaluation/assessment of the use of restraint be done quarterly and as needed for immediate intervention necessary due to use of restraint and all necessary and possible human and non-pharmacological approaches should be implemented before the use of restraint.	F 221	The Administrator in-serviced the Rehabilitation Director on the must of doing Physical Therapy evaluations in coordination with the MDS assessment for the same purpose. The Administrator in-serviced the Interdisciplinary Team (IDT) on the need to consistently strive for a restraint-free environment, exhaust all available alternative interventions prior to recommending the use of physical restraint, and to recommend only the least restrictive means based on the resident assessments and evaluations above . The Administrator further instructed the IDT to review residents on physical restraints quarterly or as often as necessary with the goal of reducing or eliminating the use of physical restraints based on the assessments and evaluations above. 4. The Medical Records Designee (MRD) will conduct monthly audit of MD orders for physical restraints to ensure that each order has corresponding initial and quarterly assessment, PT evaluation, and IDT recommendations and/or review. The MRD will report findings to the DON and Administrator for corrective action. 5. System effectiveness will be evaluated during monthly quality assurance meetings.	2/12/14 2/12/14 2/14/14 3/6/14

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F 241	Continued From page 2	F 241	F 241	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to treat 2 Confidential Resident and 3 of 15 sampled Residents with dignity and respect when, 1. Facility failed to use language understood by residents. 2. Facility failed to maintain privacy in a shared bathroom. 3. Facility failed to answer call light in a timely manner. Findings: 1. During confidential interviews, on 1/15/14 at 10:30 a.m., a resident stated that "staff speak in the room using different language and then they would start laughing as if they were talking about me." A second resident stated that he felt uncomfortable when staff spoke in a different language near him. Review of the facility Policy and Procedure on Foreign Language dated 7/12 indicated that...it is the policy of the facility to have a better communication with all the residents residing in the facility. The procedure also indicated that ..." the language to be used by the staff should be the universal English language in the resident	F 241	1. DSD made rounds to remind staff on duty to speak English only in resident care areas and that it is an all-staff responsibility to respond to call lights. DSD emphasized that responding to call a light includes identifying what the resident needs and immediately communicating that need to the staff appropriate to meet that need. DSD reminded CNAs and LNs assigned to Resident 3 and 17 to always ensure visual privacy during care, including self-care, using privacy curtains, closing both doors to the bathroom common to Resident 3's and Resident 17's rooms. Resident 3 was moved back to her original room which is adjacent to another female room following her temporary room re-assignment to effectuate infection control procedures. 2. DSD and other Department Heads continued with their daily rounds and reminded CNAs, LNs, and Unlicensed Staff alike on the above to ensure that other residents are not affected by the problems that have been identified. 3. DSD in-serviced all staff to speak English only in resident care areas and that it is an all-staff responsibility to respond to call lights. DSD emphasized that responding to call a light includes identifying what the resident needs and immediately communicating that need to the staff appropriate to meet that need. DSD instructed all CNAs and LNs to always ensure visual privacy during care,	1/17/14 1/21/14 1/22/14 to 2/5/14

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F 241	Continued From page 3 care area." The procedure also indicated that ..." no foreign language will be spoken in front of resident other than what has been illustrated earlier in this policy." During a confidential interview on 1/15/13 at 9:00 a.m., Unlicensed Staff C stated she had observed facility staff speaking Tagalog (a language spoken in the Philippines) in front of residents in the halls. 2. During an observation on 1/17/14 at 9:05 a.m., Resident 3 was lying in her bed in her room. The door to her bathroom was ajar and a male resident (Resident 17) was visible in the bathroom and was sitting on the toilet. Observation of the room adjoining that of Resident 3, revealed the bathroom door was also open in that room, Resident was visible as he stood and flushed the toilet. No staff were present in either room while Resident 17 used the toilet. Door locks were not present on the bathroom door that opened to either resident room. During an interview on 1/17/14 at 9:10 a.m., Management Staff B was asked how the facility ensured privacy in a bathroom shared by male and female residents when no locks were present on either door. She responded that staff, "do rounds" and visual checks. When she was made aware that Resident 17 used the shared toilet between his room and the room of Resident 3, without closing either door, she stated it was a privacy issue. Review of facility policy and procedure titled, "Resident Rooms with a Common Bathroom" (no date) indicated male and female residents may be assigned to rooms with a common bathroom if , "All the female and male Residents involved	F 241	including self-care, using privacy curtains, closing both doors to the bathroom common to adjacent male and rooms. The Administrator in-serviced all Department Heads on the must of equally observing the above facility rules as well as being consistent in enforcement through reminders and disciplinary actions. 4. The Administrator, DON, DSD, and other Department Heads will ensure compliance during daily rounds and through random resident interviews. The IDT will follow-up on the same during quarterly Resident Care Conferences where resident concerns and grievances are resolved. The Administrator and Social Services will continue to encourage residents in reporting specific staff for corrective action. 5. System effectiveness will be evaluated during monthly quality assurance meetings.	2/12/14 2/14/14 3/6/14

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F 241	Continued From page 4 require staff supervision/assistance during toileting." 3. Review of Resident 11's medical record, indicated she needed a wheel chair to move about. During an interview with Resident 11 on 1/16/14, at 2:45 p.m., she stated that a few weeks earlier, when she returned to the facility after dialysis (an artificial process to eliminate waste from the blood), her dialysis dressing started bleeding. Resident 11 stated that when it started bleeding, she turned on the call light and informed a CNA (Certified Nursing Assistant), who said she would tell a nurse. About 30 minutes later, a nurse came to the residents room, cleaned the bloody dressing and re-taped it. When Resident 11 asked the nurse why she didn't come sooner, the nurse said nobody told her.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet professional standards of quality for 1 random resident (Resident 18) and 1 of 15 sampled residents (Resident 10) when: 1. Licensed Staff H administered an anti-coagulant medication to Random Resident 18 without knowing the medication's indication	F 281	F 281 1. The DON counseled Licensed Staff H on the need of an LN to be proficient in all aspects of her responsibilities. Proficiency in medication pass does not only involve proper mechanics but knowledge specific to the residents receiving care from the LN such as what their medications are being given for, what result are intended, the unintended side effect to look for and monitor, and possible interaction with other medications. The DON reminded Licensed Staff H on the availability of resources including the Medication Handbook in the nurses' station, the body of the MD order and black box warning in the medication administration records, the pharmacy,	1/14/14

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F 281	Continued From page 5 (reason for use) and potential side effects (unwanted effect of the medication). These failures could result in the resident sustaining bruising, bleeding, chest pain or death. 2. Licensed staff failed to monitor and accurately document Resident 10's self-administration of DuoNeb (a liquid albuterol based medication that is put into a small hand-held device that converts it into a fine mist, which is inhaled and relaxes lung airway muscles to treat wheezing and shortness of breath) and Ventolin (an aerosolized, albuterol based, inhaled medication that opens lung airways to ease lung spasms and breathing). This failure had the potential to cause Resident 10 to experience discomfort and anxiety related to tachycardia (a racing heartbeat) chest pain, shaking, worsening trouble breathing, or other medication side effects. Findings: 1. During an observation and subsequent interview on 1/14/14 at 9:16 a.m., Licensed Staff H administered Plavix (an anti-coagulant medication with potential side effects that include bruising, bleeding, chest pain and death) to Resident 18. After administering the medication, Licensed Staff H was asked why the medication was being given to Resident 18, and what potential side effects would she monitor. Licensed Staff H stated, "I don't know what it is...I have to get the med book at the nurse's station to find out what it is for and the side effects." During an interview with Licensed Staff H on 1/14/14 at 11:40 a.m., she stated, "I looked up Plavix and Aspirin in our med book. I know what they are for now. Plavix you can give with Aspirin	F 281	pharmacy nurse consultant, the medical director, attending physicians, and the multitude of reliable internet information sites. The DON reassessed Resident 10 for self-administration and found that resident is no longer able and willing to take responsibility for documenting self-administration of her medications Resident 10 agreed to discontinue self-administration of the Duoneb and Ventolin and an MD order was obtained to discontinue the order. Nonetheless, the DON counseled the LNs who were involved with Resident 10's care that self-administration of medications must be charted sufficiently clear to indicate that medications are self-administered the resident and not administered by the LN. The DON also instructed the LNs to be alert to changes in a resident's ability and/or willingness to take responsibility for documenting self-administration of medications which should trigger reassessment to determine whether the resident should continue with self-administration. 2. There is no other resident self-administering medication(s) aside from Resident 10. The DON randomly tested LN knowledge on medications being administered to their assigned residents including but not limited to Plavix to identify resident(s) who may have been affected by the problem identified for Resident 18.	1/20/14 1//20/14 1/20/14

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F 281	Continued From page 6 to prevent heart problems or a stroke. You have to watch for bleeding, blood in the stool." Review of nursing standards of practice reference material titled, "Lippincott's Nursing Procedures, 5th Edition, Woters, Kluwer, Lippincott, Williams and Wilkins," (2008) Page 276, documented a nurse's responsibility when administering medications. It indicated that before administering a drug, in addition to checking that it is the right patient, drug, dose, route and time, the nurse needs to be aware of why the resident is getting the drug and what adverse effects to expect. An article titled, "8 Rights of Medication Administration", Lippincott's Nursing Center.Com, Nursing Center's In the Round, dated, 1/17/11, confirmed that, for patient safety, when administering medications nurses should check: a. The Right Reason. Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? b. The Right Response. Make sure that the drug led to the desired effect...Be sure to document your monitoring of the patient..." 2. During a review of the Clinical Record for Resident 10, the demographic sheet indicated that her medical history included hospice care (treatment of people with a terminal illness, which emphasizes comfort and quality of life) related end-stage COPD, (long standing chronic obstructive pulmonary disease, which makes it difficult to breath), kyphosis (abnormal shape of chest which makes it more difficult to breath) and depression (continued and/or overwhelming sadness). Physician orders in effect during the	F 281	3. The DON in-serviced all Licensed Nurses on all of the subject matter discussed in point 1 above. 4. The DON will ensure continuing compliance during new employee orientation, end of probationary period performance evaluations, and annual performance evaluations using a skills checklist. The DON will also test staff knowledge randomly during rounds. 5. System effectiveness will be evaluated during monthly quality assurance meetings.	1/23/14 to 2/15/14 2/14/14 3/6/14

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F 281	Continued From page 7 period of 1/1/14-1/1714 included, a. DuoNeb (pratropium-albuterol) Solution for Nebulization; 0.5mg-3mg(2.5 mg base)/3ml; amt: 1 neb inhalation...wheezing-SOB every 4 hours. (resident was ordered to inhale the fine mist medication once every four hours for abnormal breathing and shortness of breath). b. Ventolin HFA (albuterol sulfate) aerosol inhaler;...2 puffs,...every 6 hours...end stage COPD. (resident was ordered to inhale 2 puffs of the the aerosolized medication every 6 hours for treatment of chronic obstructive pulmonary disease c. DuoNeb (pratropium-albuterol) solution for Nebulization; 0.5 mg(2.5 mg base)/3ml; amt 1 neb inhalation...2 puffs...every 2 hours PRN end stage COPD (resident was ordered to inhale 2 puffs of the fine mist medication every two hours, AS NEEDED, for chronic obstructive airway disease) Review of the medical record, Self-Administration of Medication Assessment, dated 9/27/13, and signed by the physician and licensed nurse indicated that the resident wanted to self-administer medications, was mentally able to administer medications, was alert and oriented to person place, time and was physically able to administer medication. It documented, "Resident may keep Ventolin puff with her." During an observation and interview with Resident 10 on 1/17/14, at 9:25 a.m., she was alert and oriented, with shallow respirations. Resident 10 stated that she was a respiratory therapist and is very familiar with her lung	F 281		

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F 281	Continued From page 8 disease, which causes her to have difficulty inhaling and exhaling. Resident 10 pointed to her DuoNeb and Ventolin medications on her over-bedside table. When asked about who administers the medications, and how the nurses monitor the medications she stated that the nurses use to give her the medications but when she was short of breath and had to wait, sometimes 14 minutes, the doctor said the resident could give herself all the inhaler medications. "The nurses do not give me any inhaler or nebulizer medications anymore. I give all my inhaler and nebulizer [medications]. Sometimes they ask me how much I have given, but not every shift." During an interview with Licensed Staff I on 1/17/14 at 7:54 a.m., when asked about where the nurses documented monitoring Resident 10's self administration of medication, Licensed Staff I stated, "No, we don't have any documentation in the paper (medical record) or eMAR (electronic medication administration record) about us checking how much she has had every shift. We did check it and document how much inhaler and nebulizer she had the first time, but not after that." During a subsequent interview with Licensed Staff I, on 1/17/14, at 10:20 a.m., and review of Resident 10's eMAR, she confirmed that the nurses were documenting that they administered the DuoNeb and Ventolin, but the resident was actually self administering those medications. Licensed Staff I stated, "No, we don't administer her albuterol nebulizer or inhaler, and we don't document how much she has given herself or any side effects she had. Yes, I understand we should document what she administers and monitor it."	F 281		

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F 281	Continued From page 9 During an interview with Management Staff B, who reviewed Resident 10's electronic Medication Administration Record (eMAR) for the prior 14-day period, which incorrectly indicated that the nurses were administering the DuoNeb and Ventolin inhaler, rather than the resident who actually self administered the medications, and lacked documentation that the nurses' monitored Resident 10's self administration of medication, Management Staff B stated, "I thought the resident was just administering the PRN (as needed) inhaler nebulizer, not all her inhaler and nebulizer meds [medications]. I will inservice the nurses that they should not chart they are administering the medications. They should chart that the patient is administering the medications. The nurses will need to monitor how much she is actually giving herself and monitor for any side effects. I am going to inservice all the nurses." Review of the facility policy and procedure titled, "Self-Administration of Medications" dated July 2012, indicated, "..If the resident is able and willing to take responsibility for documenting their self-administration of medications, the resident is asked to complete a bedside record indicating the administration of the medication (if bedside storage is to be used.).. Nursing staff will review the bedside mediation record on each nursing shift, and they will transfer patient information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered."	F 281		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	F 309 - see page 11	

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F 309 SS=D	Continued From page 10 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 notify 1 of 15 sampled resident's (Resident 3) physician that she frequently fell asleep while eating and the facility did not place her on aspiration precautions (measures taken to prevent a person from choking). This failure caused Resident 3 to be at risk for choking. Findings: Review of Resident 3's medical record revealed she suffered from a brain disorder that caused extreme daytime sleepiness and sudden, irresistible bouts of sleep. During an observation on 1/16/14 at 12:30 p.m., Resident 3 was sitting on her bedside with her feet resting on the floor. Her lunch tray was on her bedside table. Unlicensed Staff U was sitting next to Resident 3 on the bed and attempting to assist her with lunch. Resident 3 completely slumped over to the right with her eyes closed. Her head rested on Unlicensed Staff U left shoulder and her body was lying on Unlicensed Staff U's left side. She appeared to be completely	F 309	1. Resident 3's physician was informed about Resident 3's bouts with sleep during meal time. Resident 3's condition has been care planned. Resident is currently on aspiration precaution and is to receive assistance during meal and snack with instructions for staff to observe if Resident 3 is falling asleep during feeding, to stop feeding and notify charge nurse. Resident 3 currently has orders for med pass and health shakes 3 times a day with meals and in between meal and HS snacks. 2. DON reviewed resident records to identify any resident with the same condition as that of Resident 3 and none was found. The Medical Records Designee checked the 24-hour report and resident records from 1/1/14 to ensure that physicians have been informed of noted changes of condition. 3. DON in-serviced all LNs on the must of immediately informing resident's attending physician regarding a change in resident's condition and formulating a plan care addressing the noted change. DSD In-serviced all CNAs to immediately report observed changes in a resident to the charge nurse. 4. The Medical Records Designee (MRD) will audit the 24-hour report and resident records to check if there is physician notification and care planning associated with any noted change of condition. MRD will provide daily report to DON for action.	1/17//14 1/25/14 1/23/14 to 2/15/14 1/22/14 to 2/5/14 2/14/14

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	055189	A. BUILDING _____ B. WING _____	01/17/2014

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F 309	Continued From page 11 asleep. Unlicensed Staff U pushed Resident 3 upright and encouraged her to open her eyes and eat some of her lunch. Resident 3 opened her eyes, took the milk offered her into her hand, swallowed a mouthful, and slumped over again onto Unlicensed Staff U. Licensed Staff U again pushed her to an upright position and again encouraged Resident 3 to eat and drink. Resident 3 slumped over to her left with her eyes closed and was now lying on her bed. She appeared to be completely asleep. Unlicensed Staff U again pushed Resident 3 up off her bed and attempted to have her sit in an upright position. Resident 3 did not eat any solid food but drank some liquids. During an interview on 1/16/14 at 12:35, Unlicensed Staff U stated Resident 3 fell over while eating in the past but said she was not sleeping. She said Resident 3 did not want to eat and was playing when she fell over. During an interview on 1/17/14 at 08:50, Unlicensed Staff T stated she had just finished feeding Resident 3 breakfast. She further stated she positioned her in the bed, with the head of the bed raised. She stated Resident 3 slumped to her side but she was able to push her upright and reposition her more easily when in bed. She added that if Resident 3 sits on the bedside with her feet on the floor, she falls over and Unlicensed Staff T has to hold her up. She further stated that Resident 3 used to get up and walk around, as recently as the previous month. She said lately, Resident 3 does not want to open her eyes, talks to her with her eyes closed, and now seldom walks. During an interview and concurrent record review	F 309	5. System effectiveness will be evaluated during monthly quality assurance meetings.	3/6/14

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F 309	Continued From page 12 on 1/17/14 at 11:40 a.m., Management Staff B stated a nurse had informed her that Resident 3 was falling asleep while eating in the dining room. Management Staff B stated she could not remember exactly when this was reported to her but that it was in the recent past. She said that at the time, she observed Resident 3 eating in the dining room. She further stated that Resident 3 was closing her eyes while eating. During an interview on 1/17/14 at 10:30 a.m., Physician N stated the facility had, "not really" informed him Resident 3 was falling asleep while eating. When queried if falling asleep while eating was a safety risk he stated, "Oh, yes." He further stated, "They will aspirate." He said Resident 3 had changes to her sleep disorder medication. The medication had been substituted and she had not received the medication for a period of time. He further stated he increased her dose the prior day. Review of Resident 3's medical record revealed she was not on aspiration precautions. Her care plan indicated she needed limited assistance when eating. During an interview on 1/17/14 at 11:40 a.m., Management Staff B stated the facility had not created a care plan addressing Resident 3 falling asleep while eating. Review of facility policy titled, "Aspiration Precaution" (dated 7/2012) revealed all residents identified as risk candidates will be monitored and placed on aspiration precautions to enhance safety and well-being. Review of facility policy titled, "Plan of Care For Resident Concern and/or change of condition" (11/2004) indicated any possible significant	F 309		

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F 309	Continued From page 13 change must be brought to the physician's attention.	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 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 that 1 out of 15 sampled residents (Resident 1) did not develop pressure ulcers, when the resident's care plans were not implemented, she was not evaluated or assessed for her refusal to turn, a care plan was not developed to address her reluctance to turn, and a wound care physician's recommendations were not followed, leading to the development of eight (8) new pressure ulcers in seven months. Findings: Review of Resident 1's MDS (Minimum Data Set, an assessment tool), indicated she had three pressure ulcers on 6/22/13. Six months later, her MDS, dated 12/10/13, indicated she had nine (9) pressure ulcers. The pressure ulcers included one Stage I (A reddened area on the skin that, when pressed, does not turn white. This is a sign that a pressure ulcer is starting to develop); two	F 314	F 314 1. Licensed Staff O obtained a routine order from MD on 1/17/14 for 2 tablets of 5-325 hydrocodone-acetamenophine to be given every 6 hours to manage Resident 1's chronic pain and potential pain during wound dressing changes and repositioning every 2 hours. DON instructed treatment nurses to schedule resident's wound dressing changes 30 minutes following administration of the pain medication and post-administration assessment of resident for pain. The DON also instructed the treatment nurses to continually assess resident for pain during wound dressing changes and to continue with treatment only as tolerated by the resident and to notify MD for new orders if resident cannot tolerate treatment under existing pain medication orders. DSD instructed CNA on duty to encourage and assist resident every 2 hours as reflected in resident's 12/23/13 care plan regarding resident's episode of refusing to be turned and repositioned and to report to the charge nurse if resident expresses pain during an attempt to reposition to resident. DSD placed extra pillows at resident's bedside to aid resident in maintaining varying degrees of position from side to side and in supplement to resident's air loss mattress. 2. DON reviewed care plans for residents receiving wound care including but not limited to	1/17/14 1/24/14

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F 314	Continued From page 14 Stage II pressure ulcers (The skin blisters or forms an open sore. The area around the sore may be red and irritated); three Stage III ulcers (The skin now develops an open, sunken hole called a crater. There is damage to the tissue below the skin); one Stage IV pressure ulcer (The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints), and two unstageable pressure ulcers (full thickness skin or tissue loss, with depth not known due to a covering of dead tissue in the wound base). Wound physician progress notes, dated 1/9/14, indicated Resident 1 had two new Stage I pressure ulcers on her left hip, bringing the total pressure ulcers to eleven (11) The same notes indicated, the resident needed turning every two hours and "She needs Kinair [KinAir] Mattress" [a pressure reducing mattress, with air flotation, 20 degree turning capability, and assists in repositioning residents]. Observations, on 1/13/14, revealed Resident 1 was not in a KinAir bed. When asked why the resident was not in the recommended bed, on 1/17/14 at 11:40 a.m., Management Staff B stated the facility notified the resident's primary physician (Physician N) regarding the wound doctor's recommendation for the KinAir bed. She stated the facility did not order one as Physician N said the resident's current low air loss mattress was adequate. Observation, on 1/16/14 at 9:45 a.m., revealed Resident 1 had ten pressure ulcer dressings in place, plus one wound that did not have the dressing changed that day. There were two staff at her bedside, CNA E to help reposition the	F 314	pain management and wound prevention interventions to ensure the residents do not encounter the findings for Resident 1. 3. The DON in-serviced all charge and treatment nurses on the must of recognizing signs and indications for pain assessment, management, and control including but not limited a resident refusing to be moved or repositioned, having wounds, and undergoing daily treatment for wounds. DON pointed out that assessment must be done not only when the resident is in an undisturbed and still position but also during attempts to move or reposition the resident or during wound dressing changes. The DON emphasized that pain management requires a team approach where pre-medication makes way for treatment nurses to change wound dressings and for CNAs to implement care plans for the prevention of a resident developing wounds including turning and repositioning. The DSD in-serviced all CNAs on the must of turning and repositioning all residents every two hours to prevent pressure related wounds from developing. The DSD also pointed out the importance of relaying key information to the charge nurse such as a resident's refusal to be turned or repositioned or a resident's expression of pain during turning or repositioning so that the resident can be assessed by the charge nurse immediately. The DON also in-serviced all the LNs and the DSD	1/23/14 to 2/15/14 1/22/14 to 2/5/14 1/23/14 to 2/15/14

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F 314	Continued From page 15 resident and Licensed Staff D to change the ten pressure ulcer dressings. Resident 1 was repositioned multiple times during the dressing changes and grimaced throughout the procedure. Resident 1 was repositioned to change the dressings on her left lower leg (5 x 3 inches, beefy red in color, with underlying bone clearly visible) and her right knee (2 x 2 inches and red in color). The resident cried out, "Ow! Ow!" verbally expressing pain. Her eyes filled with tears. Licensed Staff D asked if the resident wanted the dressing changes stopped, but did not inquire about the potential for the use of pain medication. Resident 1's History and Physical, dated 10/13/13 that indicated Resident 1 suffered from chronic pain. She had physician orders for Hydrocodone (narcotic pain medication) one to two tablets be given as needed. During an interview on 1/16/14 at 12:00 p.m., Licensed Staff D stated she did not pre-medicate Resident 1 prior to the dressing changes. She stated that Licensed Staff O medicated residents. Review of the resident's MAR (Medication Administration Record) revealed the resident received her last "as needed" pain medication at 7:30 a.m., greater than two hours before the dressing changes. During an interview on 1/16/14 at 12:25 p.m., Licensed Staff O stated she gave Resident 1 her pain medication when she asked for it. During concurrent observation and interview on 1/17/14 at 8:20 a.m., Resident 1 was lying very still, on her back in bed. She stated that she did	F 314	in-serviced all the CNAs in the use of common items such as pillows in preventing wounds by enabling a resident to maintain positions at varying degrees from side to side and to protect pressure points including heels and elbows. 4. The DON will ensure compliance by reviewing weekly wound reports and looking at numerical trends on nosocomial wounds. The DON and DSD will ensure that residents are being turned and repositioned by doing rounds randomly throughout the day. The DON and DSD will also randomly interview residents during their rounds on whether they experience pain while sitting still, when turning or repositioning, during wound dressing changes, or during ADL. The charge nurses will do the same while passing medications and treatment nurses during treatment. 5. System effectiveness will be evaluated during monthly quality assurance meetings.	2/14/14 3/6/14

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F 314	Continued From page 16 not have pain at the time because she was not moving. When asked, she stated her dressing changes were painful, "Yes! Every time!" When asked to describe her pain during dressing changes on a scale of 1-10 (1 being no pain and 10 being the worst pain you can imagine), she responded, "10!" When asked if she would like pain medication before beginning a dressing change, she responded, "They can do that?" Additionally, the resident stated that her wound care doctor told her she was supposed to turn to prevent pressure ulcers, but "I don't want to." She stated that turning and repositioning were too painful and she would turn and reposition if she had no pain. She further stated she would like pain medication before her dressing changes. During a confidential interview on 1/16/13 at 11:05 a.m., a family member of Resident 1 stated that Resident 1 was always in pain. The family member stated that when he observed Resident 1 being turned by staff, she would cry in pain During an interview on 1/17/14, CNA R stated she is sometimes unable to reposition Resident 1 every two hours because Resident 1 tells her she is in pain. She stated that when this happens she tells the nurse. During an interview on 1/17/14 at 1:10 p.m., Licensed Staff Q stated she assessed Resident 1 and she was aware that the resident 1 had a history of chronic pain. She stated she did not ask Resident 1 if she had pain with turning. When queried if she asked Resident 1 if she had pain during her dressing changes, Licensed Staff Q did not respond.	F 314		

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F 314	Continued From page 17 During an interview on 1/17/14 at 10:35 a.m., Physician N stated pain management for Resident 1 was a priority and she should always be pre-medicated with pain medication before pressure ulcer dressing changes and repositioning. When asked if he was aware Resident 1 was resisting repositioning due to pain, he responded he was not aware of that. Resident 1's care plan for "At risk for pain or discomfort," dated 7/5/13, had interventions including administer pain meds as ordered; assess effects of pain on resident; and assess for signs and symptoms of pain (speaking or non-verbal, including grimacing). There was no documented evidence that the facility implemented these interventions to meet the resident's needs. There was no documented evidence, and the facility did not provide evidence, that the resident was assessed and evaluated for her refusal to turn or for her pain during repositioning. Facility documentation indicated Resident 1 had daily dressing changes for her pressure ulcers, from December 19, 2013 through January 12, 2014. Review of Resident 1's MAR (Medication Administration Record) indicated that during this same time frame, from December 19, 2013 to January 12, 2014 (3+ weeks), Resident 1 did not receive any of the Hydrocodone that her physician had ordered for her. Resident 1's MAR indicated that Resident 1 did receive the pain medication on 1/13/14, 1/15/14, and 1/16/14 (the week when State surveyors were in the facility). Review of facility document titled, "Policy and	F 314		

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F 314	Continued From page 18 Procedure on Pain Management" (dated 11/2012) indicated residents will have pain management in accordance to his/her need. The document revealed pain medication will be administered to the resident per MD order. The document further indicated that residents will be positioned for comfort.	F 314		
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: The facility failed to provide a safe environment free of accident hazards when, 1. A safety needle, also sometimes referred to as a safety syringe (a needle and plunger device that has a "pull-up" needle cover, which decreases the chance of a nurse or someone else inadvertently piercing their skin) was not used during administration of insulin, in 1 random resident (Resident 19), which created a hazard for a needle stick injury and subsequent transmission of infection or disease to the resident, visitors and staff. 2. A towel was left on the floor, next to the bed, in 1 of 15 sampled residents (Resident 5), which created a fall hazard for the resident, visitors and staff.	F 323	F323 1. The DON removed all non-safety syringes from the central supply room and medication carts for disposal. Nonetheless, DON reminded Licensed Staff J to always adhere to the facility's safety procedures and that recapping the syringe as he did was not safe. Management Staff A removed the towel on the floor in Resident 5's area. Management Staff A reminded Unlicensed Staff K on the must of enforcing safety rules and immediately involving Management Staff if needed to articulate reasons to residents. 2. Management Staff B rechecked the central supply room and medication carts to ensure that non-safety syringes have been totally put out of use. DSD made rounds in resident rooms in order to identify and remove similar hazards as that found in Resident 5's area. 3. The DSD in-serviced CNAs on the must of identifying, immediately reporting, and/or making on the spot corrections, hazards in resident areas including but not limited to clutters or objects on	1/14/14 1/15/14 1/22//14 to 2/5/14

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F 323	Continued From page 19 Findings: 1. During an observation on 1/14/14 at 11:52 a.m., in Resident 19's room, Licensed staff J administered an injection of Insulin (medication that lowers blood sugar) to Resident 19 and then re-capped the needle with one hand (place the narrow orange cap back over the sharp end of the needle). The facility policy and procedure titled "Needles and Cuts" Revised 6/12, documented, "It is the policy of this facility that all personnel must follow our facility's fixed procedures to assist in preventing injuries caused by needle sticks, sharp blades, broken glass, or other sharp instruments or devices...To aide in preventing needle stick injuries, needles shall not be recapped..." During an observation and subsequent interview with Management Staff B on 1/15/14 at 3:10 p.m., in the Central Supply Room, noted a box of more than 20 packaged, unopened, safety syringes labeled "Monoject Safety Syringe 1/2 ml. " In the same box were 10, syringes that were not safety syringes and can be re-capped, labeled "1 cc ml VanishPoint Insulin Syringe. When Management Staff B was asked why some of the syringes were safety syringes and some were not, she stated, "I'm not sure, I think a vendor probably left these samples (pointing to the non-safety syringes that can be recapped) and we are just using them." When asked about how the facility decides on what type of patient care equipment is ordered and used, including syringes, she stated, "I'm not sure how they are ordered." Management Staff B and Management Staff G	F 323	floors, spilled liquids, loose baseboard, cracked tiles, un-retracted bed cranks, and the like. The DON informed all LNs that non-safety syringes have been discontinued and instructed each to discard of any non-safe syringe if any is left in the medication cart or central supply room. The DON in-serviced LNs on safety while passing medications including but not limited keeping the medication carts locked at all times in between dispensing medications, sharps containers at safe levels, trash bin lids closed, and sanitizing of medication cart surfaces. The Administrator in-serviced Department Heads to do the same during daily environmental rounds using the Environmental Rounds Checklist. 4. The Administrator, DON, DSD, and other Department Heads will ensure continuing compliance during rounds using the Environmental Checklist. 5. System effectiveness will be evaluated during monthly quality assurance meetings.	1/23/14 to 2/15/14 2/12/14 2/14/14 3/6/14

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F 323	Continued From page 20 were interviewed, on 1/14/14 at 3:15 p.m., in the room behind the nursing station. When asked about how the facility determines what patient care supplies, including needles and syringes, to use, Management Staff G stated, "The corporate office has a Safety Committee that meets monthly and it's interdisciplinary, to prevent staff injuries and resident injuries. The committee decides on the products all our buildings (facilities) will use. We decided all facilities, and this one, will use safety syringes since June 2013. The facility orders the syringes and needles from our corporate office...No, they shouldn't use those non-safety syringes." At 3:18 p.m., Management Staff B stated, "I'll go through the supplies and get rid of the syringes that aren't safety caps." The facility policy and procedure titled "Ordering of Medial Supplies", Revised 7/12, indicated that the facility designee will do monthly inventory and any supplies needed will be discussed with [Management Staff B's title] for approval. Once approved, the designee will submit the order list to the corporate/vendor website if needed. On 1/17/14 at 2:34 p.m., Management Staff B stated that there were no other policies or procedures concerning the use of safety needles in the facility. 2. During an observation on 1/17/14 at 7:25 a.m., Resident 5 was asleep in his bed. There was a white bath towel shaped in a circle, on the dry, shiny floor next to his bed. Review of Resident 5's Medical Record, Demographic Sheet revealed he had diagnoses including muscle weakness, Parkinson's disease (progressive illness that impacts muscle	F 323		

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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 323	Continued From page 21 coordination and walking), and dementia (progressive illness that impact's ability to think and remember). During an interview on 1/17/14 at 7:28 a.m., in Resident 5's room, when asked about the towel on the floor, Unlicensed Staff K stated, "Oh, that's his preference, he likes it there. He can pick it up if he wants. We try to remove it but he puts it back." During an interview on 1/17/14 at 7:33 a.m., in Resident 5's room, when asked about the towel on the floor, Management Staff A stated, "...Of course it's not safe, we will try to get a long rug. He thinks the floor is cold."	F 323		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on food production observation, resident and dietary staff interviews, and dietary document review, the facility failed to ensure resident's foods were prepared in a method that maintain palatability and safety when breakfast foods were served at incorrect temperatures. This failure had the potential to compromise the nutritional status of residents who are already physically vulnerable. Foods served at incorrect	F 364	F 364 - IDR requested on 2/17/14 1. Interviews of alert residents throughout the facility regarding breakfast food temperature in response to Resident Council Meeting minutes identifying cold breakfast being served in Wing D as an ongoing concern, have consistently resulted in a couple of alert residents in Wing D stating that breakfast is delivered cold most of the time. To address this concern, dietary staff announces via the facility's public announcement system when each food cart is ready to ensure that resident trays are delivered promptly to preserve food temperature. On follow-up interviews, the identified residents stated that breakfast temperature have somewhat improved but have not improved enough.	1/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. BUILDING _____ B. WING _____	01/17/2014

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F 364	Continued From page 22 temperatures may be unappetizing and may result in decreased food intake in residents requiring adequate calories, protein and nutrients. Meat and milk served at incorrect temperatures may lead to food borne illness. Findings: During confidential interviews on 1/13/14 at 10:30 a.m., multiple confidential residents complained food was being served cold, especially during breakfast. Review of Resident Council Minutes, on 1/14/13, revealed multiple on-going complaints about cold food, dating back almost one year. The issue was, "not resolved." During an observation of tray line on 1/16/14, a small container containing sausage patties was located on top of the steam table, not in it. A container of pureed eggs was located inside the steam table. The temperature of the sausage during a test tray (food temperature just prior to tray leaving kitchen) was 104 degrees prior to leaving the kitchen. The temperature of the pureed eggs was 133 degrees. During an observation of breakfast tray line (food preparation in which resident food trays move along an assembly line to be filled) on 1/17/14 at 6:40 a.m., multiple bowls of oatmeal covered with plastic lids were on gray serving trays. Multiple trays of oatmeal bowls were located on top of the serving island, not on the steam table (serving table that helps keep food warm). The kitchen delivered food to residents on 4 separate food carts. Dietary staff used the bowls of oatmeal off the steam table in the first 3 carts.	F 364	During rounds at around 6:00AM on 1/16/14, Administrator identified that there is only two hours to warm breakfast plates, from the time dietary staff clock in for work at 5:00AM to the start of breakfast at 7:00AM as compared to a 3 to 4 hour lead time for lunch and dinner. The Administrator instructed the Maintenance Assistant to install a timer for the plate warmer to ensure the same lead time for breakfast. To also ensure that breakfast to be served in bowls is kept warm, the Dietary Supervisor instructed the dietary staff to serve breakfast items such as oatmeal one food cart at a time. The Dietary Supervisor also instructed the staff to ensure that drinks such as milk are taken out of the refrigerator as close to serving time as possible to attain recommended tray line serving temperature. Follow-up resident interviews indicate that the concern over cold breakfast is resolved. 2. The facility increased the number of Registered Dietician hours from 8 to 20 hours per week to ensure ample resources for troubleshooting and dietary staff development. The Dietary Supervisor is no longer with the facility and the facility will ensure that the successor is skilled in staff training, supervision, troubleshooting, and sustained process improvement. 3. The Registered Dietician in-serviced the dietary staff on the must of ensuring that food and drinks are served at recommended temperatures for all three	2/12/14 2/14/14 and 2/17/14

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F 364	Continued From page 23 Dietary staff used oatmeal located inside the steam table on the 4th food cart. Management Staff IP tested one bowl of oatmeal at 7:21 a.m. and the reading was 133 degrees Fahrenheit prior to leaving the kitchen. During an interview on 1/17/147:50 a.m., Management Staff P stated staff were expected to only fill enough bowls for the 1st food cart. During an interview and concurrent test tray (random testing of a food tray to determine temperature and palatability) on 1/17/14 at 7:34 a.m., the temperature of the oatmeal was 116 degrees, the temperature of pureed eggs was 116 degrees and the temperature of a small carton of milk was 42.6 degrees. Management Staff P stated the oatmeal was " luke-warm" and pureed eggs were "luke-warm." Review of facility document titled, "Meal Service" (dated 3/13) revealed food temperatures will be served on tray line at recommended temperatures and indicated the following temperatures: Meat 155-160 degrees, eggs 145 - 155 degrees, milk 41 degrees or less.	F 364	meal servings. To accomplish uniformity and consistency, 1) set-up such as lead time for the plate warmer and steam table temperature must also be uniform and consistent and 2) processes, such as serving bowls of oatmeal from the steam table one food cart at a time and taking drinks such as milk from the refrigerator as close to serving time as possible, must be followed at all times. The in-service included a post-test. 4. The Registered Dietician and Dietary Supervisor will ensure continuing compliance by supervising and observing tray line. The Administrator will observe tray line at random times and request for sample trays to ensure to same. 5. System effectiveness will be evaluated during monthly quality assurance meetings.	2/14/14 3/6/14
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 - IDR requested on 2/17/14 1. Unlicensed Staff C and Management Staff P followed through with daily procedures and maintained the sanitizing solution according to manufacturer's guidelines by testing the concentration prior to use, discarding the solution that did not meet the guideline, and refilling bucket	1/15/14