Reviewed & accepted 02/15/13

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

PRINTED: 01/29/2013
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 |
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| | 555759 | A. BUILDING _____ B. WING _____ | 01/11/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the Department of Public Health during a Recertification Survey.<br><br>Representing the Department of Public Health:<br><br>Surveyor ID #27680<br>Surveyor ID #14330<br>Surveyor ID #31331<br><br>Total Resident Population: 103<br>Total Resident Sample Size: 21<br><br>Highest Scope and Severity: E | F 000 | Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907.(KF) | |
| F 167 SS=B | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure the most recent survey result was available for examination in a place that was readily accessible to the residents. The deficit practice had the potential to result in a violation of the right to examine the results of the most recent | F 167 | Immediate Correction:<br>A copy of the most recent survey was posted in the dining room 1/11/13 by the Activities Director so it is readily available to residents.<br><br>Others at Risk:<br>An in-service was given to Department Managers 2/1/13 to ensure that a recent survey is posted in the dining room for resident accessibility each year.<br><br>Preventing Reoccurrence:<br>Rounds will be made daily by Department Managers to ensure most recent survey is posted in the dining room for resident access and review. | 2/12/13 |

2012 FEB 13 PM 4:03

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Karen Zugate | Administrator | 2/12/13 |

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

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| F 167 | Continued From page 1<br>survey for 103 residents residing in the facility.<br><br>Findings:<br><br>On January 9, 2013 at 9 a.m., the facility survey results posted in the dining room were reviewed. The annual survey that was posted was dated August 9, 2010. The most recent annual facility survey however, was completed on November 22, 2011. The most recent survey of the facility was not accessible or posted in the facility for examination. On the subsequent days of the survey January 10, and 11, 2013, the most recent survey of the facility was not accessible and was not posted.<br><br>During a group resident interview, on January 9, 2013, at 10:30 a.m., eleven of eleven alert residents that attended the meeting, stated that they would like to review the survey results but were unaware of the posting of the survey results.<br><br>On January 10, 2013 at 7:45 a.m., the director of nursing (DON) and the director of staff developer (DSD) were informed that the most current survey was not posted for the residents. During an interview at that time, the DSD stated that the survey should be posted in the dining room or in the breeze-way. The most current survey was not posted in either location, however.<br><br>The facility policy titled "Posting," dated year 2008, indicated the availability of the survey results should be posted in a place readily accessible to residents. | F 167 | Reminders of the posting of the recent surveys will be discussed in Resident Council monthly for resident awareness.<br><br>CQI to review monthly for any feedback and follow up with corrections as needed.<br><br>Monitoring Process:<br>Monitoring to be done via rounds by Department Managers daily and monthly in Resident Council to ensure compliance. | |
| F 246 SS=E | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES | F 246 | | |

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| F 246 | Continued From page 2<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that the residents had access to a telephone in order to call their family members without having to ask the staff. Seven of eleven alert and oriented residents who attended the group interview and one sampled resident (10) stated that they are unable to call their family members when they wanted to because the facility pay phone had been broken for about three months. This had the potential to result in a decline in independent functioning for the use of the telephone to accommodate for the residents communication needs.<br><br>Findings:<br><br>During a general observation on January 9, 2013 at 7:25 a.m., a random resident complained to the surveyor about the pay phone in the breeze-way being broken. According to the resident, the pay phone had been broken for a while.<br><br>During an observation on January 9, 2013 at 7:25 a.m., the director of staff development (DSD) and the surveyor inspected the pay phone located in | F 246 | Immediate Correction:<br>The pay phone in the breezeway was repaired 1/10/13 by AT&T repair service.<br><br>Others at Risk:<br>An in-service was given to all staff on 2/1/13 by Administrator to report pay phone disruption immediately and remind residents of availability of business phone usage as an alternative.<br><br>Preventing Reoccurrence:<br>Rounds will be made daily by Department Managers to ensure pay phone is in good functioning and report immediately any need for repair.<br><br>Social Service Designee will be responsible to contact phone company repair immediately and continue follow up until pay phone is repaired.<br><br>Monthly Resident Council meetings will review proper functioning of pay phone and that business phones are available when pay phone not in use. | 2/12/13 |

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| F 246 | Continued From page 3<br>the breeze-way. The pay phone had no dial tone. According to the DSD, the pay phone broke two days ago and someone was supposed to come and fix it.<br><br>On January 9, 2013 at 10 a.m., during a group interview, seven of eleven alert and oriented residents complained that the pay phone in the breeze-way had been broken for about three months. The residents stated that the facility staff already knew about the problem. The residents further stated that this prevented them from calling their family members any time they wanted to.<br><br>On January 9, 2013 at 2:40 p.m., during an interview with Resident 10, she stated that the pay phone had been broken for a while. Resident 10 stated that she had been wanting to call her parents and "it breaks her heart" that she could not call and talk to them.<br><br>During an interview with the social service designee (SSD) on January 10, 2013 at 8 a.m., she stated that the pay phone broke less than two weeks ago. The SSD stated that she had been trying to call the pay phone company to come and fix the phone.<br><br>The facility's undated policy and procedure titled "Policy: Repair of Personal/Facility Property," indicated to assure that the resident's rights to have personal/facility property in good repair are preserved, all personal resident items and facility equipment are in good working condition, within the facility's capabilities. The policy indicated that repair services are contacted as soon as possible to provide repairs and any items needing repair | F 246 | Monitoring Process:<br>Monitored by Department Managers on daily rounds and monthly in Resident Council. | |

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| F 246 | Continued From page 4<br>would be noted promptly in a log book at the nursing stations or maintenance contacted directly. | F 246 | Immediate Correction:<br>1. Resident rooms 7, 20, 21, 25, 26, 28, 29 and 31 had television antennas secured 1/9/13 by Maintenance.<br>2. The fan in Room 31 was secured 1/9/13 by Maintenance<br>3. The television in Room 5 was secured 1/9/13 by Maintenance<br><br>Others at Risk:<br>Maintenance Supervisor inspected all resident rooms on 1/10/13 to ensure that televisions, antennas and fans were secured for the safety of the residents. Corrections were made as needed on that day.<br><br>An in-service was given to all staff on 2/1/13 by Administrator to report any unsecured resident equipment immediately so corrections can be made.<br><br>Preventing Reoccurrence:<br>Rounds will be made daily by Department Managers to ensure televisions, antennas, fans and any other resident equipment is secured for safety. Reports made to Maintenance for prompt correction. | 2/12/13 |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and policy review, the facility failed to provide a resident environment that is free from hazards for residents who were housed in a locked unit environment. Room 7, 20, 21, 25, 26, 28, 29, and 31, had unsecured simple half-wave dipole metal television antennas ("rabbit ears"). Room 31 had an unsecured electrical 16 inch blade fan. Room 5 had an unsecured television. The facility failed identify hazards in the nine rooms (Rooms 7, 20, 21, 25, 26, 28, 29, 31, 5). This had the potential to result in accidents that can lead to injuries of the residents.<br><br>Findings:<br><br>During a general observation, with the director of staff developer (DSD), on January 9, 2013 at 8:05 a.m., the following were identified:<br>1. Eight rooms (Room 7, 20, 21, 25, 26, 28, 29, and 31) had televisions that were equipped with | F 323 | | |

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| F 323 | Continued From page 5<br>unsecured simple half-wave dipole metal antennas ("rabbit ears"). (A resident could accidentally injure himself on the unsecured metal antenna).<br>2. An unsecured electrical 16 inch plastic blade fan (Room 31). (In the event of an earthquake, the unsecured electrical fan could fall on a resident and possibly injure a resident).<br>3. An unsecured television (Room 5). (In the event of an earthquake, the unsecured television set could fall on a resident and possibly injure a resident).<br>During an interview with the DSD on January 9, 2013 at 8:15 a.m., she stated that the fan and television antennas were a hazard to the residents.<br>The facility's undated policy and procedure titled "Safe Environment," indicated the lock unit environment will be safe and hazard free. | F 323 | Monthly Resident Council meetings will review need for securing residents' personal property for safety.<br><br>Safety Committee will make rounds to ensure resident equipment is secured. Report to Maintenance for immediate correction.<br><br>Monitoring Process:<br>Monitoring by Department Managers via daily rounds and monthly in Resident Council and Safety Committee rounds. | |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents 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 | F 329 | | |

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| F 329 | Continued From page 6<br>record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that a gradual dose reductions were attempted for 13 of 18 residents (1, 3, 4, 5, 8, 14, 15, 11, 12, 13, 16, 17, 18) who received psychotherapeutic drugs in a total sample of 21 residents. This had the potential to result in significant adverse consequences from possible excessive doses, inadequate monitoring, and prolonged use of psychotherapeutic medications.<br><br>Findings:<br><br>a. A review of the Admission Record of Resident 11 indicated that the resident was originally admitted to the facility on March 17, 2009, and was readmitted on January 17, 2011, with diagnoses that included schizophrenia paranoid type (mental condition characterized by prominent delusions and hallucinations that wax and wane across recurrent psychotic episodes), depression, and cognitive impairment.<br><br>A review of the recapitulation of the physician's orders for January 2013 indicated the following medication orders: | F 329 | Immediate Correction:<br>a) resident 11 had a reduction by psychiatrist of:<br>1. Depakote ER 1000mg QAM and QHS to 1000mg QAM and 750mg QHS beginning 1/17/13<br>2. Zoloft 50mg QAM to 25mg QAM beginning 1/29/12<br>3. Neurontin 600mg QID to 600mg TID 1/17/13<br>4. Topamax 400mg BID to 350mg BID 1/29/13<br>5. Thorazine 200mg BID to 175mg BID 1/29/13<br>6. Seroquel 600mg QHS to 550mg QHS 1/29/13<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system. | 2/12/13 |

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| F 329 | Continued From page 7<br><br>1.Depakote ER 500 milligrams (mg) every morning (q am) and 1000 mg every night at bedtime (qhs) for paranoid schizophrenia manifested by mood swing such as hypo/hyperactivity, ordered on January 17, 2011.<br>2. Zoloft 50 mg every morning for depression manifested by isolative behavior with minimal interaction with others, ordered on December 6, 2011.<br>3. Neurontin 600 mg four times a day for schizophrenia paranoid type manifested by mood swings such as friendly to hostile behavior, ordered on January 17, 2011.<br>4. Topamax 400 mg twice a day for schizophrenia paranoid type manifested by mood swings such as happy to sad behavior, ordered on January 17, 2011.<br>5. Thorazine 200 mg twice a day for schizophrenia paranoid type manifested by paranoid, suspicious, and guarded behavior, ordered on February 24, 2011.<br>6. Seroquel 600 mg every night at bedtime for schizophrenia paranoid type manifested by auditory hallucinations such as mumbling and talking to self inappropriately, ordered on September 8, 2011.<br><br>A review of the care plans for the use of the antipsychotic and antidepressant medications dated July 31, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated October 29, 2012, indicated the resident was able to complete the brief interview for mental status, | F 329 | An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. Disseminated was: All residents with antipsychotic drugs the first year of use will have GDR attempted in two separate quarters-at least a month a part in the year, unless clinically contraindicated. after the first year, the GDR will be attempted annually, unless clinically contraindicated.<br><br>Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring. | |

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| F 329 | Continued From page 8<br>able to understand others and make herself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antipsychotic and antidepressant during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received the above ordered medications from January 1, 2013 through January 9, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from January 2012 through December 2012:<br><br>1. Resident 11 had about 26 to 48 episodes of mood swings manifested by hypo/hyperactivity daily while on Depakote ER 500 mg and 1000 mg.<br>2. Resident 11 had about of 25 to 45 episodes of isolative and withdrawn behavior daily while on Zoloft 50 mg.<br>3. Resident 11 had about 24 to 46 episodes of hostile to friendly behavior daily while on Neurontin 600 mg.<br>4. Resident 11 had about 28 to 43 episodes of mood swings manifested by happy to sad behavior daily while on Topamax 400 mg.<br>5. Resident 11 had about 17 to 48 episodes of paranoid, suspicious, and guarded behavior daily while on Thorazine 200 mg.<br>6. Resident 11 had about 35 to 45 episodes of mumbling and talking to self inappropriately daily while on Seroquel 600 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated January 27, 2012, February 27, 2012, March 31, 2012, April 30, 2012, May 31, 2012, June 30, 2012, July 20, 2012, August 30, | F 329 | The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, GDR dates, and notification to DON for follow up.<br><br>The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly.<br><br>A Physician Psychotherapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated. | |

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| F 329 | Continued From page 9<br>2012, September 28, 2012, October 22, 2012, November 30, 2012, and December 22, 2012, indicated that a dose reduction is not advised. The notes further indicated to continue the resident's current medication regimen because the resident is benefiting from it and may develop symptoms without medications. However, there was no documented evidence of a resident-specific clinical rationale describing why a gradual dose reduction would be clinically contraindicated. In addition, there was no documented evidence of a past failed attempt to gradually reduce the doses of these medications.<br><br>During an interview with the director of nursing (DON) on January 9, 2013, at 2:30 p.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Depakote, Zoloft, Neurontin, Topamax, Thorazine, and Seroquel since these medications were ordered by the physician in 2011.<br><br>During an observation on January 11, 2013 at 7:10 a.m., Resident 11 was observed in the dining room eating her breakfast meal.<br><br>On January 11, 2013 at 10:31 a.m., during an interview, Resident 11 stated she would sometimes participate in group activities, but prefers to stay in her room. The resident was alert, pleasant, friendly, and cooperative.<br><br>The facility's undated policy and procedure titled "Policy: Psychotherapeutic Medications" indicated that drug holidays and gradual dose reductions are to be encouraged as the resident's condition allows and all medication regimens are to be | F 329 | Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| F 329 | Continued From page 10<br>reviewed quarterly at the interdisciplinary team conference with the resident or representative.<br><br>b. A review of the Admission Record of Resident 12 indicated that the resident was admitted to the facility on February 10, 1981, with diagnoses that included schizophrenia (mental disorder in which a person interpret reality abnormally characterized by hallucinations, delusions, and disordered thinking, and behavior), depression, and organic brain syndrome.<br><br>A review of the recapitulation of the physician's orders for January 2013 indicated the following medication orders:<br><br>1. Haldol Decanoate 25 milligrams (mg) intramuscular (IM) every 28th of the month for schizophrenia manifested by increased agitation such as provoking others to fight with her, ordered on September 19, 2011.<br>2. Desyrel 25 mg every night at bedtime for depression manifested by isolative and antisocial behavior such as minimal interaction with others and constant crying without appropriate reason, ordered on November 28, 2011.<br><br>A review of the care plans for the use of the antipsychotic and antidepressant medications dated September 29, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>The MDS dated December 29, 2012, indicated the resident was able to complete the brief interview for mental status, able to understand others and make herself understood, and was independent with most activities of daily living. | F 329 | Immediate Correction:<br>b) resident 12 had a reduction by psychiatrist of:<br>1. Haldol Decanoate 25mg to 20mg 1/17/13,<br>2. Desyrel 25mg QHS to 12.5mg QHS 1/17/13,<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system.<br><br>An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. Disseminated was: All residents with antipsychotic drugs the first year of use will have GDR attempted in two separate quarters-at least a month a part in the year, unless clinically contraindicated. after the first year, the GDR will be attempted annually, unless clinically contraindicated. | 2/12/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555759 | A. BUILDING _____ B. WING _____ | 01/11/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTEREY CARE | 1287 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

| (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 |
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| F 329 | Continued From page 11<br>The MDS further indicated the resident received an antipsychotic and antidepressant during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received Desyrel daily from January 1, 2013 through January 10, 2013, and is scheduled to receive the Haldol on January 28, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from January 2012 through December 2012:<br><br>1. Resident 12 had about 3 to 38 episodes of increased agitation such as provoking others to fight with her daily while on Haldol Decanoate 25 mg.<br>2. Resident 12 had about 22 to 44 episodes of depression manifested by isolative and antisocial behavior such as minimal interaction with others and 14 to 43 episodes of constant crying without appropriate reason daily while on Desyrel 25 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated February 27, 2012, March 31, 2012, April 30, 2012, May 31, 2012, June 30, 2012, July 20, 2012, August 30, 2012, September 28, 2012, October 22, 2012, November 30, 2012, and December 22, 2012, indicated that a dose reduction is not advised. The notes further indicated to continue the resident's current medication regimen because the resident is benefiting from it and may develop symptoms without medications.<br><br>According to a Note to Attending Physician/Prescriber dated August 30, 2012 and November 2, 2012, the facility's consultant | F 329 | Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring.<br><br>The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, DGR dates, and notification to DON for follow up. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 12<br>pharmacist recommended to attempt a gradual dose reduction for Haldol and Desyrel. A review of the physician/prescriber response indicated "No change in medication at this time, resident needs current dose of medication." However, there was no documented evidence of a resident-specific clinical rationale describing why a gradual dose reduction would be clinically contraindicated. In addition, there was no documented evidence of a past failed attempt to gradually reduce the doses of these medications.<br><br>During an observation on January 9, 2013, at 7:10 a.m., Resident 12 was observed sitting in the breeze-way with other residents. The resident was alert, ambulatory, and pleasant.<br><br>During an interview with the director of nursing (DON) on January 10, 2013 at 9:30 a.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Haldol Decanoate and Desyrel since these medications were ordered by the physician in 2011.<br><br>During an interview on January 11, 2013, at 7:30 a.m., Resident 12 stated that she is doing "okay." The resident was alert and pleasant with no agitation or crying behavior observed.<br><br>c. A review of the Admission Record of Resident 13 indicated that the resident was admitted to the facility on December 24, 2004, with diagnoses that included schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems), bipolar disorder (a condition in which people go back and forth between periods of a very good or irritable | F 329 | The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly.<br><br>A Physician Psycho therapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated.<br><br>Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 13<br>mood and depression), obsessive compulsive disorder, anxiety disorder, and borderline personality disorder (mental illness marked by unstable moods, behavior, and relationships).<br><br>A review of the recapitulation of the physician's orders for January 2013 indicated the following medication orders:<br><br>1. Lithium Carbonate 300 mg three times a day for bipolar disorder manifested by mood swings such as happy to sad behavior, ordered on December 24, 2007.<br>2. Seroquel 100 mg twice a day for chronic schizoaffective disorder manifested by agitation such as yelling, screaming, and verbally abusive behavior, ordered on March 9, 2010.<br>3. Haldol Decanoate 100 mg intramuscular every two weeks for schizoaffective disorder manifested by agitation such as being verbally abusive to the staff, ordered on December 23, 2010.<br><br>The MDS dated December 8, 2012, indicated the resident was able to complete the brief interview for mental status, able to understand others and make herself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antipsychotic, antianxiety, and antidepressant during the last seven days.<br><br>A review of the care plans for the use of the antipsychotic, antianxiety, and antidepressant medications dated December 11, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction. The medication administration record (MAR) revealed that the resident received the above ordered medications | F 329 | Immediate Correction:<br>c) resident 13 had a reduction by psychiatrist of:<br>1. Lithium Carbonate 300mg TID to 300mg BID 1/17/13.<br>2. Seroquel 100mg BID to 100mg QAM 1/17/13.<br>3. Haldol Decanoate 100mg to 75mg 1/29/13.<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system.<br><br>An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. | 2/12/13 |

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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 |
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| F 329 | Continued From page 14<br>daily from January 1, 2013 through January 10, 2013, and last received the Haldol on January 7, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from January 2012 through December 2012:<br><br>1. Resident 13 had about 29 to 47 episodes of mood swings manifested by happy to sad behavior daily while on Lithium 300 mg.<br>2. Resident 13 had about 34 to 47 episodes of agitation manifested by yelling, screaming, and verbally abusive behavior while on Seroquel 100 mg.<br>3. Resident 13 had about 19 to 46 episodes of agitation manifested by being verbally abusive to the staff while on Haldol Decanoate 100 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated June 30, 2012, July 20, 2012, August 30, 2012, September 28, 2012, October 22, 2012, and December 22, 2012, indicated that a dose reduction is not advised. The notes further indicated to continue the resident's current medication regimen because the resident is benefiting from it and may develop symptoms without medications. However, there was no documented evidence of a resident-specific clinical rationale describing why a gradual dose reduction would be clinically contraindicated. In addition, there was no documented evidence of a past failed attempt to gradually reduce the doses of these medications.<br><br>During an interview with the director of nursing (DON) on January 10, 2013, at 10 a.m. and January 11, 2013, at 8:20 a.m., she reviewed the | F 329 | Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring.<br><br>The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, DGR dates, and notification to DON for follow up.<br><br>The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 15<br>clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Lithium, Seroquel, and Haldol Decanoate since these medications were ordered by the physician in 2007 and 2010.<br>During an observation on January 11, 2013, at 7:15 a.m., Resident 13 was observed walking in the East unit hallway. The resident was alert, cooperative, and pleasant and had no verbally abusive behavior observed.<br><br>d. A review of the Admission Record of Resident 17 indicated that the resident was admitted to the facility on March 3, 2009, with diagnoses that included schizophrenia paranoid type (mental condition characterized by prominent delusions and hallucinations that wax and wane across recurrent psychotic episodes) and depression.<br><br>A review of the recapitulation of the physician's orders for January 2013 indicated the following medication orders:<br><br>1. Neurontin 300 mg three times a day for schizophrenia paranoid type manifested by mood swings such as calm to noisy behavior, ordered on March 3, 2009.<br>2. Seroquel 200 mg twice a day ordered on May 2, 2009, and Seroquel 100 mg every noontime ordered on July 30, 2010, for schizophrenia paranoid type manifested by auditory hallucinations such as mumbling, laughing, and talking to self incoherently and responding to unseen stimuli.<br>3. Celexa 10 mg every night for depression manifested by isolative and withdrawn behavior, ordered on April 11, 2010. | F 329 | A Physician Psycho therapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated.<br><br>Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 16<br><br>A review of the care plans for the use of the antipsychotic and antidepressant medications dated September 11, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>The MDS dated December 10, 2012, indicated the resident was able to complete the brief interview for mental status, able to understand others and make herself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antipsychotic and antidepressant during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received the above ordered medications daily from January 1, 2013 through January 10, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from January 2012 through December 2012:<br><br>1. Resident 17 had about 29 to 45 episodes of mood swings manifested by calm to noisy behavior daily while on Neurontin 300 mg.<br>2. Resident 17 had about 36 to 51 episodes of auditory hallucinations manifested by mumbling, laughing, and talking to self incoherently and responding to unseen stimuli daily while on Seroquel 200 mg.<br>3. Resident 17 had about 27 to 47 episodes of depression manifested by isolative and withdrawn behavior while on Celexa 10 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated September 28, 2012, October 22, | F 329 | Immediate Correction:<br>d) resident 17 had a reduction by psychiatrist of:<br>1. Neurontin 300mg TID to 200mg BID and 100mg at noon 1/17/13.<br>2. Seroquel 200mg BID and 100mg noon to 150mg TID1/17/13.<br>3. Celexa 10mg QHS to 5mg QHS on 1/29/13.<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system.<br><br>An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. | 2/12/13 |

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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 17<br>2012, November 30, 2012, and December 22, 2012, indicated that a dose reduction is not advised. The notes further indicated to continue the resident's current medication regimen because the resident is benefiting from it and may develop symptoms without medications. However, there was no documented evidence of a resident-specific clinical rationale describing why a gradual dose reduction would be clinically contraindicated. In addition, there was no documented evidence of a past failed attempt to gradually reduce the doses of these medications.<br><br>During an observation on January 11, 2013, at 7:10 a.m., Resident 17 was observed in the dining room eating her breakfast meal.<br><br>At 7:25 a.m., on the same date, the resident was observed walking in the hallway. The resident stated she has no complaints and was just waiting for the dentist to come and pull out her teeth. The resident was alert, pleasant, and cooperative.<br><br>During an interview with the director of nursing (DON) on January 11, 2013, at 8:20 a.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Neurontin, Seroquel, and Celexa since these medications were ordered by the physician in 2009 and 2010.<br><br>e. A review of the Admission Record of Resident 18 indicated that the resident was originally admitted to the facility on September 22, 2009, and was readmitted on January 14, 2011, with diagnoses that included schizoaffective disorder (a mental condition that causes both a loss of | F 329 | Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring.<br><br>The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, DGR dates, and notification to DON for follow up.<br><br>The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly. | |

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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 18<br>contact with reality (psychosis) and mood problems), depression, and cognitive impairment.<br><br>A review of the recapitulation of the physician's orders for January 2013 indicated the following medication orders:<br><br>1. Haldol 10 mg every morning and every night at bedtime for schizoaffective disorder manifested by delusions such as believing that there are aliens in Finland that is communicating with her, ordered on January 14, 2011.<br>2. Depakote ER 500 mg every night at bedtime for schizoaffective disorder manifested by mood swings such as friendly to hostile behavior, ordered on February 11, 2011.<br>3. Abilify 15 mg every morning and every night at bedtime for schizoaffective disorder manifested by hallucinations such as mumbling and talking to self inappropriately, ordered on February 11, 2011.<br><br>A review of the care plans for the use of the antipsychotic medications dated October 1, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>The MDS dated December 31, 2012, indicated the resident was able to complete the brief interview for mental status, able to understand others and make herself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antipsychotic during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received the above ordered medications daily from January 1, 2013 through January 11, 2013. | F 329 | A Physician Psycho therapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated.<br><br>Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| F 329 | Continued From page 19<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from January 2012 through December 2012:<br><br>1. Resident 18 had about 2 to 42 episodes of delusions manifested by believing that there are aliens in Finland that is communicating with her while on Haldol 10 mg.<br>2. Resident 18 had about 36 to 45 episodes of mood swings manifested by friendly to hostile behavior while on Depakote 500 mg.<br>3. Resident 18 had about 28 to 44 episodes of hallucinations manifested by mumbling and talking to self inappropriately while on Abilify 15 mg.<br><br>A review of Psychiatric Progress Notes dated May 19, 2012, June 30, 2012, July 28, 2012, August 26, 2012, September 30, 2012, October 28, 2012, November 19, 2012, and December 23, 2012, indicated that the resident was alert, cooperative, calm, and is responding to the treatment. The notes further indicated to continue the medications, observe the resident for compliance and deterioration in function, and titrate the medications according to the symptoms. However, there was no documented evidence of a resident-specific clinical rationale describing why a gradual dose reduction would be clinically contraindicated. In addition, there was no documented evidence of a past failed attempt to gradually reduce the doses of these medications.<br><br>During an observation on January 11, 2013, at 7:10 a.m., Resident 18 was observed in the dining room eating her breakfast meal. | F 329 | Immediate Correction:<br>e) resident 18 had a reduction by psychiatrist of:<br>1. Haldol 10mg QAM and night to 10mgQAM and 7.5mg at night 1/17/13.<br>2. Depakote ER 500mg QHS was discontinued and Depakote Sprinkle ~~was~~ 375mg at HS was ordered. 1/17/13.<br>3. Abilify 15mg QAM and QHS to 12mg QAM and 15mg QHS 1/29/13.<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system.<br><br>An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. | 2/12/13 |

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| F 329 | Continued From page 20<br><br>At 7:20 a.m., on the same date, Resident 18 was observed walking towards her room. The resident was alert, pleasant, friendly, and cooperative. According to the resident, she is doing "good" and she likes living in the facility.<br><br>During an interview with the director of nursing (DON) on January 11, 2013, at 8:20 a.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Haldol, Depakote, and Abilify since these medications were ordered by the physician in 2011.<br><br>The facility's undated policy and procedure titled "Policy: Psychotherapeutic Medications" indicated that drug holidays and gradual dose reductions are to be encouraged as the resident's condition allows and all medication regimens are to be reviewed quarterly at the interdisciplinary team conference with the resident or representative.<br>f. Resident 1 was originally admitted to the facility on 1/19/04, with diagnoses that included schizoaffective chronic (mental disorder characterized by recurring abnormal mood and psychiatric component), bipolar disorder (mood disorder in which people experience disruptive mood swing) , depressive disorder, peptic ulcer (most common area of the gastrointestinal tract that is usually acidic and extremely painful) and diabetes mellitus (high blood sugar).<br><br>The MDS dated 12/29/12, indicated the resident had a short term memory recall problem and was given an antidepressant and antipsychotic drugs in the past seven days. The medication administration record (MAR) revealed that Effexor | F 329 | Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring.<br><br>The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, DGR dates, and notification to DON for follow up.<br><br>The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly. | |

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| | 555759 | A. BUILDING _____ B. WING _____ | 01/11/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTEREY CARE | 1257 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 21<br>XR 75 mg, Risperdal 2 mg, Haldol 10 mg and Haldol 5 mg were given to Resident 1 everyday from 1/1/13 through 1/10/13.<br><br>A review of the physician's medication orders revealed the following:<br><br>1. Effexor XR (antidepressant) tablet 75 mg by mouth daily was ordered on 8/21/108, for depression as manifested by isolative behavior and minimum interaction with others<br>2. Risperdal (antipsychotic) 2 mg one tablet by mouth twice a day was ordered on 4/16/10, for schizoaffective chronic as manifested by auditory hallucinations such as mumbles and talks to self inappropriately.<br>3. Haldol (antipsychotic) 10 mg by mouth twice a day was ordered on 9/21/11, for schizoaffective chronic as manifested by delusions such as believes others are plotting against him and verbally abusive towards staff.<br>4. Haldol (antipsychotic) 5 mg by mouth every 12 noon was ordered on 9/21/11, for schizoaffective chronic as manifested by delusions such as believes others are plotting against him and verbally abusive towards staff.<br><br>A review of the psychotropic summary sheets from 1/1/12 through 12/31/12, the resident's behavior were as follows:<br><br>1. Resident 1 had about 7-47 episodes of isolative behavior and minimum interaction with others while on Effexor XR 75 mg daily.<br>2. Resident 1 had about 8-52 episodes of auditory hallucinations as manifested by mumbles and talks to self inappropriately while on Risperdal 2 mg daily. | F 329 | A Physician Psycho therapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated.<br><br>Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| F 329 | Continued From page 22<br>3. Resident 1 had about 5-45 episodes of delusion as manifested by believes others are plotting against him and 13-47 episodes of verbally abusive to staff while on Haldol 15 mg daily.<br><br>A review of the psychiatrist progress notes dated 2/24/12, 3/25/12, 6/30/12, 7/28/12, 9/30/12, 10/31/12, revealed the resident was alert, cooperative and responded to treatment.<br><br>On 1/8/13 at 2:15 p.m., the medical record of Resident 1 was reviewed with the Director of Nursing (DON). The DON disclosed the resident's record had no documented evidence that gradual dose reduction of Effexor, Risperdal and Haldol was attempted since ordered. The resident's record did not contain information of the clinical rationale that gradual dose reduction would be clinically contraindicated for Resident's 1. The resident's plan of care for the use of antidepressant drug (12/30/12) and antipsychotic drug (12/30/12) did not indicate re-evaluation of resident's behavior for gradual dose reduction.<br><br>g. Resident 3 was originally admitted on 6/2/08, with diagnoses that included schizoaffective, depressive disorder and diabetes mellitus. A review of the physician's order sheet dated 6/2/08, indicated Klonopin (antianxiety) was ordered to be given 1 mg by mouth three times a day for anxiety as manifested by making repetitive questions. On 5/22/11, the physician ordered Zyprexa (antipsychotic) 15 mg by mouth every bedtime for schizoaffective disorder as manifested by hallucinations such as mumbles and talks to self inappropriately. | F 329 | Immediate Correction:<br>f) resident 1 had a change by psychiatrist of:<br>1. Effexor XR 75mg daily to 37.5mgQD 1/16/13.<br>2. Risperdal 2mg BID to 2mg QAM and 1.5mg QPM 2/1/13.<br>3. Haldol 10mg BID remained the same but changed in #4 below.<br>4. Haldol 5mg at noon daily was discontinued 2/1/13.<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system.<br><br>An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. | 2/12/13 |

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| F 329 | Continued From page 23<br>During an observation on 1/10/13 at 10:45 a.m., the resident was seen in his room watching television. The resident disclosed he participated in group activities everyday but prefers to watch television and to read newspaper in his room. The resident was ambulatory, cooperative, alert and coherent.<br><br>A review of the medication administration record (MAR) dated 1/1/13 through 1/10/13, revealed Klonopin 1 mg 3 three times daily and Zyprexa 15 mg every bedtime were given to Resident 3. The psychotropic summary sheet dated 1/1/12 through 12/31/12, revealed the resident had about 30-50 episodes of making repetitive questions while on Klonopin 1 mg. The resident had about 32-51 episodes of mumbling and talking to self inappropriately while on Zyprexa 15 mg.<br><br>According to the psychiatrist progress notes dated 12/23/12, the resident was responding to treatment, alert, cooperative and stated, " I'm doing good, looking forward with drug holidays." During an interview on 1/10/13 at 11:15 a.m., the Director of Nursing stated she did not know why the psychiatrist did not consider gradual dose reduction for Klonopin and Zyprexa. The DON disclosed there was no documented clinical rationale in the resident's medical record as to why an attempt to gradually reduce the dosage of Klonopin and Zyprexa would be clinically contraindicated. The resident's plan of care for the use of antianxiety drug (12/11/12) and antipsychotic drug (12/11/12) did not indicate re-evaluation of resident's behavior if may benefit from gradual dose reduction. There was no documented evidence of a past failed attempt to | F 329 | Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring.<br><br>The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, DGR dates, and notification to DON for follow up.<br><br>The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly. | |

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| F 329 | Continued From page 24<br>reduce Klonopin and Zyprexa since ordered.<br><br>h. Resident 4 was readmitted to the facility on 4/8/11,with diagnoses that included schizophrenia, depression, cognitive impairment and anemia (a condition in which the body does not have enough healthy red blood cells).<br><br>On 9/19/11, the physician ordered Prozac (antidepressant) 5 mg by mouth everyday for depression as manifested by isolative behavior and minimum interaction with others. The medication administration record (MAR) dated 1/1/13 through 1/10/13, revealed Prozac 5 mg was given to Resident 4 at 9 a.m., everyday. The psychotropic summary sheet dated 1/1/12 through 12/31/12 , revealed the resident had about 36-48 episodes of isolative behavior and minimum interaction with others. A review of the resident's plan of care for the use of an antidepressant drug dated 12/6/12, did not indicate re-evaluation of resident's behavior for gradual dose reduction.<br><br>According to psychiatrist progress notes dated 12/22/12, dose reduction of Prozac 5 mg was not advised and resident may develop symptoms without medication. However, there was no documented clinical rationale in the resident's medical record as to why gradual dose reduction would be clinically contraindicated. There was no documented evidence of a past failed attempt to reduce the dosage of Prozac 5 mg since ordered on 9/19/11.<br><br>On 1/10/13 at 11 a.m., Resident 4 was observed in bed alert and coherent. The resident disclosed that she just got back from group activities. The | F 329 | A Physician Psycho therapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated.<br><br>Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| F 329 | Continued From page 25<br>resident stated, "I'm happy here."<br><br>i. Resident 14 was readmitted on 2/22/10, with diagnoses that included schizophrenia paranoid (suspiciousness) anxiety, dementia and seizure disorder. On 1/11/13 at 1:40 p.m., the resident was observed in the activity room talking to her peers. The resident was cooperative, alert and coherent.<br><br>A review of the physician medication orders revealed the following:<br><br>1. Risperdal (antipsychotic) 2 mg one tablet by mouth twice daily and 2 mg every bedtime was ordered on 2/22/10, for schizophrenia paranoid type as manifested by hallucination as manifested by verbally aggressive to staff and peers.<br><br>2. Klonopin (antianxiety) 0.5 mg by mouth twice daily was ordered on 2/22/10, for anxiety as manifested by pacing and wandering around.<br><br>A review of the medication administration record dated 1/1/13 through 1/11/13, disclosed that 6 mg total daily dosage of Risperdal and 1 mg total daily dosage of Klonopin were given to Resident 14. The psychotropic summary sheet dated 1/1/12 through 12/31/12, indicated the resident had decreased episodes of pacing and wandering around. The resident had about 1-40 episodes of verbally aggressive to staff and peers. The resident's plan of care for the use of antipsychotic (12/6/12) and antianxiety (12/6/12) did not indicate re-evaluation of resident's behavior for gradual dose reduction. A review of the psychiatrist progress notes dated 12/23/12, revealed the resident was alert, friendly and | F 329 | Immediate Correction:<br>g) resident 3 had a change by psychiatrist of:<br>1. Klonopin 1mg TID to 1mg BID 1/17/13<br>2. Zyprexa 15mg at HS to 10mg HS 1/17/13.<br>**Zyprexa was returned to original dosage on 1/30/13 due to increased hallucinations.<br><br>Others at Risk:<br>All residents with antipsychotic drugs have been entered on a log by the Director of Nursing (DON) on 2/2/13 with the start date of the medication. A gradual dose reduction will be attempted per regulations during the year utilizing this system.<br><br>An in-service was given to the Licensed Personnel on 1/29/13 by the DON regarding gradual dose reduction (GDR) regulations for antipsychotic drugs. | 3/12/13 |

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| F 329 | Continued From page 26<br>responded to treatment.<br><br>During an interview on 1/10 at 1:58 p.m., the DON disclosed there was no documented evidence in the resident's medical record that gradual dose reduction of Risperdal and Klonopin was attempted since ordered on 2/22/10.<br><br>j. Resident 15 was readmitted on 1/14/09, with diagnoses that included schizophrenia, bipolar disorder, cognitive impairment and hypothyroidism (a condition in which the thyroid gland does not make enough thyroid hormone). On 1/11/13 at 1:30 p.m., the resident was observed alert and quiet in the hallway.<br><br>A review of the physician's medication orders revealed the following:<br><br>1. Depakote DR (anticonvulsant use for mood stabilizer) 250 mg by mouth three times daily was ordered on 3/2/09, for bipolar disorder as manifested by moodswing such as friendly to hostile behavior.<br><br>2. Seroquel (antipsychotic) 25 mg by mouth every bedtime was ordered on 1/14/09, for schizophrenia paranoid type as manifested by hallucinations such as talks, laughs to self and responding to unseen stimuli.<br><br>A review of the psychotropic summary sheets from 1/1/12 through 12/31/12, the resident's behavior were as follows:<br><br>1. Resident 15 had about 38-48 episodes of moodswings while on Depakote DR 250 mg three times daily. | F 329 | Preventing Reoccurrence:<br>The DON will review physician telephone orders daily to monitor orders of antipsychotic drugs for new orders, reductions or increases in medications. The orders will be added to the GDR log book and reviewed daily for attempts to reduce the antipsychotics.<br><br>The RN Supervisor will document daily, in the nursing communication book, the new or changed orders of the antipsychotic drugs. The DON will review the communication book daily and record changes of drugs in the GDR log book for continual monitoring.<br><br>The monthly recaps will be done by the RN Supervisor with review of the antipsychotics including start dates, DGR dates, and notification to DON for follow up.<br><br>The Pharmacy Consultant will provide monthly random reviews of antipsychotic drugs to ensure GDRs have been attempted and documented on resident records. DON will follow up on recommendations promptly. | |

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| F 329 | Continued From page 27<br><br>2. Resident 15 had about 34-45 episodes of hallucinations while on Seroquel 25 mg daily.<br><br>A review of the medication administration record dated 1/1/13 through 1/10/13, revealed that Risperdal 25 mg every bedtime and Depakote DR 25 mg three times daily were given to Resident 15.<br><br>A review of the resident's plan of care for the use of Depakote (7/21/12) and Seroquel (7/21/12) did not indicate re-evaluation of resident's behavior for gradual dose reduction. The resident's record did not have documented evidence that gradual dose reduction for Depakote and Seroquel were attempted since ordered. The psychiatrist progress notes dated 12/23/12, revealed the resident was alert and cooperative and responded to treatment. However, the resident's record did not contain information of clinical rationale that dose reduction of Depakote and Seroquel would be clinically contraindicated.<br>k. A review of the Admission Record of Resident 5 indicated that the resident was originally admitted to the facility on September 14, 2011, with diagnoses that included bipolar (condition in which people go back and forth between periods of a very good or irritable mood and depression), cognitive impairment, anxiety, and depression.<br><br>A review of the recapitulation of the physician's orders for January 2013, indicated the following medication orders:<br><br>1. Ativan (anti-anxiety medication) 0.5 mg twice a day for anxiety manifested by constant pacing and restlessness, ordered on October 14, 2011. | F 329 | A Physician Psycho therapeutic Intervention Progress Note will be completed by the physician monthly with documentation regarding GDR and behaviors, therapy approaches attempted, reasons to continue current antipsychotic medication and clinical rationale why attempted dose reduction is contraindicated.<br><br>Medical Records will audit monthly to ensure changes in antipsychotic medication have been monitored and documented properly.<br><br>CQI Committee will review data monthly and follow up as needed.<br><br>Monitoring Process:<br>Monitoring by DON via telephone orders, nursing communication book, GDR Log Book, Pharmacy Consultant reports, Medical Records audits daily and monthly. RN Supervisor will monitor with recaps monthly. | |

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| F 329 | Continued From page 28<br><br>2. Remeron (anti-depressant medication) 30 mg at night for depression manifested by limited interaction with others, ordered on September 14, 2011.<br><br>A review of the care plan for the use of the antidepressant medications dated September 24, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>A review of the care plan for the use of the antianxiety medications dated September 24, 2012, indicated dependence may occur and medication may need to be tapered with discontinuing (gradual dose reduction).<br><br>The MDS dated December 23, 2012, indicated the resident was moderately impaired based on the brief interview for mental status, the resident was able to understand others and make himself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antianxiety and antidepressant during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received the above ordered medications from January 1, 2013 through January 10, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from September 2012 through December 2012:<br><br>1. Resident 5 had about 26 to 31 episodes of depression manifested by minimum interaction with others while on Remeron 30 mg. | F 329 | Immediate Correction:<br>h) resident 4 had a change by psychiatrist of:<br>1. Prozac 5mg daily to discontinued 1/17/13<br><br>Others at Risk:<br>Please refer to #a) for plan for others at risk<br><br>Preventing Reoccurrence:<br>Please refer to # a) for plan for preventing reoccurrence<br><br>Monitoring Process:<br>Please refer to # a) for monitoring process.<br><br>Immediate Correction:<br>i) resident 14 had a change by psychiatrist of:<br>1. Risperdal 2mg BID and 2mg QHS to 2mg BID and 1mg QHS 1/17/13<br>**increased Risperdal back to 2MG QHS 1/29/13 due to increased agitation and aggression.<br>2. Klonopin .5mg BID to .5mg daily 1/17/13. | 2/12/13<br><br>2/12/13 |

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| F 329 | Continued From page 29<br>2. Resident 5 had 2 episodes of anxiety manifested by pacing constantly and restlessness while on Ativan 0.5 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated January 25, 2012, February 24, 2012, March 25, 2012, April 22, 2012, May 19, 2012, June 30, 2012, July 28, 2012, August 26, 2012, September 30, 2012, October 30, 2012, November 19, 2012, and December 23, 2012, indicated that medication should be reduced according to symptoms. However, there were no orders or documentation in the resident clinical record that indicated the specific clinical justification of not attempting the titration (gradual dose reduction), of the medications.<br><br>During an interview with the director of nursing (DON) on January 10, 2013 at 10:10 a.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Ativan and Remeron since these medications were ordered by the physician in 2011.<br><br>During an observation on January 9, 2013 at 8 a.m., Resident 5 was observed in the dining room eating his breakfast meal. The resident was alert, in good spirits and friendly.<br><br>I. A review of the Admission Record of Resident 8 indicated that the resident was originally admitted to the facility on April 12, 2010 and readmitted on March 19, 2011, with diagnoses that included cognitive impairment, schizoaffective disordered (condition in which a combination of schizophrenia symptoms such as hallucinations or delusions and of mood disorder symptoms, | F 329 | Others at Risk:<br>Please refer to # a) for plan for preventing reoccurrence.<br><br>Preventing Reoccurrence:<br>Please refer to # a) for plan of preventing reoccurrence.<br><br>Monitoring Process:<br>Please refer to # a) for monitoring process.<br><br>Immediate Correction:<br>j) resident 15 had a change by psychiatrist of:<br>1. Depakote DR 250mg TID to 250mg BID 1/17/13 **increased back to 250mg TID 1/21/13 due to very hostile and dangerous mood swings.<br>2. Seroquel 25mg QHS to 12.5mg QHS 2/1/13<br><br>Others at Risk:<br>Please refer to # a) for plan for others at risk.<br><br>Preventing Reoccurrence:<br>Please refer to # a) for plan of preventing reoccurrence. | 2/12/13 |

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| - | 555759 | A. BUILDING _____ B. WING _____ | 01/11/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MONTEREY CARE | 1267 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

| (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 |
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| F 329 | Continued From page 30<br>such as mania or depression), and psychosis (loss of contact with reality that usually includes false beliefs about what is taking place or who one is and seeing or hearing things that aren't there).<br><br>A review of the recapitulation of the physician's orders for January 2013, indicated the following medication orders:<br><br>1. Seroquel (anti-psychotic medication) 200 mg four times a day for agitation manifested by verbally abusive with others, ordered on October 25, 2011.<br><br>A review of the care plan for the use of the antipsychotic medication dated April 27, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>The MDS dated October 26, 2012, indicated the resident was cognitively intact based on the brief interview for mental status, was able to understand others and make himself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antipsychotic medication during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received the above ordered medications from January 1, 2013, through January 9, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from October 2011 through December 2012:<br><br>1. Resident 8 had about 3 to 49 episodes of depression manifested by being verbally abusive | F 329 | Monitoring Process:<br>Please refer to # a) for monitoring process.<br><br>Immediate Correction:<br>k) resident 5 had a change by psychiatrist of:<br>1. Ativan .5mg BID to .5mg QD 2/1/13.<br>2. Remeron 30mg QHS to 15mg QHS 2/1/13<br><br>Others at Risk:<br>Please refer to # a) for plan for others at risk.<br><br>Preventing Reoccurrence:<br>Please refer to # a) for plan of preventing reoccurrence.<br><br>Monitoring Process:<br>Please refer to # a) for monitoring process. | 2/12/13 |

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| F 329 | Continued From page 31<br>with others while on Seroquel 200 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated January 14, 2012, February 28, 2012, March 27, 2012, April 24, 2012, May 22, 2012, June 30, 2012, July 26, 2012, August 27, 2012, September 17, 2012, October 30, 2012, November 26, 2012, and December 27, 2012, indicated it was clinically contraindicated for a gradual dose reduction (GDR). However, there was no documentation of resident specific clinical justification of not attempting the GDR.<br><br>During an interview with the director of nursing (DON) on January 9, 2013, at 4 p.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Seroquel after the medication were ordered by the physician in 2011.<br><br>During an interview with Resident 8 on January 9, 2013 at 3:40 p.m., he stated he felt good and had no concerns with the facility.<br><br>m. A review of the Admission Record of Resident 16 indicated that the resident was originally admitted to the facility on November 18, 1999, and was readmitted on August 28, 2009, with diagnoses that included schizophrenia (a mental disorder that makes it hard to tell the difference between what is real and not real, think clearly, have normal emotional responses, and act normally in social situations), depression, psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions).<br><br>A review of the recapitulation of the physician's | F 329 | Immediate Correction:<br>1) resident 8 had a change by psychiatrist of:<br>1. Seroquel 200mg QID-no change this medication at this time. MD feels this would cause risk for exacerbation of symptoms.<br>**Risperdal reduced instead from 4mg to 2mg on 1/9/13.<br>**Decompensated on 1/24/13 and sent to acute hospital.<br><br>Others at Risk:<br>Please refer to # a) for plan for others at risk.<br><br>Preventing Reoccurrence:<br>Please refer to # a) for plan of preventing reoccurrence.<br><br>Monitoring Process:<br>Please refer to # a) for monitoring process. | 2/12/13 |

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| F 329 | Continued From page 32<br>orders for January 2013, indicated the following medication orders:<br><br>1. Lithium Carbonate (mood stabilizer medication) 900 mg at night for mood swing manifested by calm to noisy behavior, ordered on September 13, 2012.<br><br>2. Desyrel (antidepressant medication) 100 mg at night for depression manifested by isolative behavior, antisocial, and minimum interaction with others, ordered on August 31, 2009.<br><br>A review of the care plan for the use of the antidepressant and mood stabilizer medications dated October 11, 2012, did not indicate when to reevaluate the resident for a gradual dose reduction.<br><br>The MDS dated January 7, 2013, indicated the resident was cognitively intact based on the brief interview for mental status, was able to understand others and make himself understood, and was independent with most activities of daily living. The MDS further indicated the resident received an antipsychotic and antidepressant medication during the last seven days. In addition, the medication administration record (MAR) revealed that the resident received Lithium Carbonate and Desyrel as the physician ordered from January 1, 2013, through January 10, 2013.<br><br>A review of the Psychotropic Summary Sheet disclosed the following behavior data from October 2011 through December 2012:<br><br>1. Resident 16 had about 17 to 54 episodes of mood swing manifested by calm to noisy behavior | F 329 | Immediate Correction:<br>m) Resident 16 had a change by psychiatrist of:<br>1. Lithium Carbonate 900mg QHS to 750mg QHS 2/1/13.<br>2. Desyrel 100mg QHS to 75mg QHS 1/17/113.<br><br>Others at Risk:<br>Please refer to # a) for plan for others at risk.<br><br>Preventing Reoccurrence:<br>Please refer to # a) for plan of preventing reoccurrence.<br><br>Monitoring Process:<br>Please refer to # a) for monitoring process. | 2/12/13 |

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| MONTEREY CARE | 1257 SAN GABRIEL BLVD ROSEMEAD, CA 91770 |

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| F 329 | Continued From page 33<br>while on Lithium Carbonate 900 mg.<br><br>2. Resident 16 had about 8 to 38 episodes of depression manifested by isolative behavior, antisocial, and minimum interaction with others while on Desyrel 100 mg.<br><br>A review of the Psychiatric Follow-up/Therapy notes dated January 27, 2012, February 27, 2012, March 31, 2012, April 30, 2012, May 31, 2012, June 30, 2012, July 20, 2012, August 30, 2012, September 28, 2012, October 22, 2012, November 30, 2012, and December 12, 2012, indicated it was not advised for a gradual dose reduction (GDR). However, there was no documentation of resident specific clinical justification of not attempting the GDR.<br><br>During an interview with Resident 16, on January 10, 2013, at 4:15 p.m., he stated he felt good. The resident was taking a walk in the patio.<br><br>During an interview with the director of nursing (DON) on January 10, 2013, at 4:55 p.m., she reviewed the clinical record and was unable to find documented evidence that a gradual dose reduction was attempted for the Lithium Carbonate and Desyrel after the medications were ordered by the physician in the year 2012 and in the year 2009. | F 371 | Immediate Correction:<br>a) The 84 small sticky bowls were rewashed immediately on 1/8/13 and inspected by Dietary Supervisor to ensure they were well cleaned.<br>b) The 30 bowls and 15 cover plates were rewashed and dried thoroughly on 1/8/13. Dietary Supervisor inspected to ensure cleanliness.<br>c) The seven dish racks were replaced with new racks on 1/9/13 by Dietary Supervisor.<br>d) The soy sauce was discarded on 1/8/13 by Dietary Supervisor.<br><br>Others at Risk:<br>An in-service was given to Dietary staff on 1/9/13 by Dietary Supervisor to ensure:<br>a) small bowls are thoroughly cleaned and devoid of any dark brownish material and stickiness.<br>b) bowls and cover plates are not stacked while wet<br>c) dish racks are monitored that there are no black brownish materials covering the racks<br>d) Soy sauce will be discarded after one year of opening. | 2/12/13 |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food | | | |

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| F 371 | Continued From page 34<br>under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility staff failed to air dry the dinnerware, maintain the dish racks and dinnerware under sanitary conditions and discard a food item (soy sauce) that was stored without an expiration date.<br><br>Findings include:<br><br>During kitchen tour on 1/8/13 at 7:15 a.m., the following were observed:<br><br>a) 84 small bowls with dark brownish material on the base and rim of the bowls and were sticky when touched.<br>b) 30 bowls and 15 cover plates were stacked up while still wet.<br>c) Seven dish racks with black brownish material covering the entire rack.<br>d) One gallon of unrefrigerated soy sauce (Rich in All) with approximately a half gallon left had, with an open date of 10/15/11, did not have an expiration date on the product label. (The manufacturer recommends discarding one year after opening product).<br><br>A review of the facility's undated policy for mechanical dishwasher and dry goods storage, revealed that dishes should not be stored when wet and the maximum storage period for sauce should be six months if unopened. | F 371 | Preventing Reoccurrence:<br>Dietary Supervisor will monitor the small bowls, bowls and cover plates and dish racks for cleanliness daily for 4 weeks and randomly thereafter.<br>Any opened soy sauce will be monitored by the Dietary Supervisor weekly to ensure proper disposal within a year after opening.<br><br>Monthly Safety inspections will encompass review of bowls, covers, plates, dish racks for good repair and cleanliness. Follow up as needed for corrections promptly.<br><br>Monthly Dietitian Consultant reviews of Dietary cleanliness to include condition and cleanliness of bowls, covers, plates, dish racks. Corrections to be followed up promptly.<br><br>CQI quarterly audits will ensure compliance being met with bowls, covers, plates, dish racks in good repair and clean. Corrections made as deficiencies found. | |

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| F 371 | Continued From page 35<br><br>During an interview on 1/8/13 at 8 a.m., the dietary supervisor stated that the afternoon dishwasher did not follow the facility's policy to air dry the bowls. The dietary supervisor disclosed that the dish racks were old and would be replaced. The dietary supervisor also said that the staff was not aware that an expiration date was not on the product label of the soy sauce. | F 371 | Monitoring Process:<br>Monitoring by Dietary Supervisor daily and randomly via inspection, Monthly by Safety Committee and Dietitian Consultant audits, and CQI quarterly audits. | |
| F 457 SS=E | 483.70(d)(1)(i) BEDROOMS ACCOMODATE NO MORE THAN 4 RESIDENTS<br><br>Bedrooms must accommodate no more than four residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that 6 of 28 resident rooms (Rooms 1, 5, 20, 26, 44 and 45) accommodated no more than four residents in each room.<br><br>Findings:<br><br>On January 8, 2013, at 8:10 a.m., during the entrance conference while conducting a re-certification survey of the facility, the director of nursing (DON) was interviewed regarding facility rooms occupied by more than four residents. The DON stated that a room waiver would be submitted for resident rooms which had five or more residents in each of the rooms.<br><br>During the re-certification survey of the facility on January 8, 2013, at 10:30 a.m., the evaluator reviewed the room waiver request submitted by | F 457 | Immediate Correction:<br>Facility will provide a smooth, gradual decrease, by attrition, in the number of licensed beds from 103 beds to 96 beds as per currently mailed facility license.<br><br>Others at Risk:<br>No other rooms are at risk. They meet the standard requirements for number of beds in a room.<br><br>Preventing Reoccurrence:<br>The facility will take measures to ensure the residents in Rooms 1, 4, 20, 26, 44, and 45 continue to not be adversely affected in health and safety by the extra number of beds in their rooms.<br><br>This will be monitored daily via rounds by Department Managers, Administrator, DON, and/or Charge Nurses. | 2/12/13 |

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| F 457 | Continued From page 36<br>the administrator for 6 of the 28 resident rooms. The room were:<br><br>Room — Beds per Room — Square Feet<br>1 — 12 — 1110<br>5 — 8 — 550<br>20 — 12 — 1110<br>26 — 8 — 571<br>44 — 5 — 379.5<br>45 — 12 — 1036<br><br>Further review of the facility's survey file revealed that a decision was reached to deny a similar resident room size waiver request presented to Department of Health and Human Services, Centers for Medicare and Medicaid Services on May 25, 2012.<br><br>The bedrooms must accommodate no more than four residents. Rooms # 1, 5, 26 and 44 were denied a waiver request. The residents in these rooms had psychiatric diagnoses with behavioral problems. The rooms size requirement did not appear to be in accordance with the special needs of the residents and may adversely affect the health and safety of the residents. | F 457 | The CQI Committee and Safety Committee will monitor and follow up monthly as needed.<br><br>Monitoring Process:<br>Monitoring will be accomplished by Department Managers, Administrator, DON, Charge Nurses and Safety Committee via rounds.<br><br>Immediate Correction:<br>Facility will provide a smooth, gradual decrease, by attrition, in the number of licensed beds from 103 beds to 96 beds as per currently mailed facility license.<br><br>Others at Risk:<br>No other rooms are at risk. They meet the 80 square feet per residents in multiple resident rooms. | 2/12/13 |
| F 458 SS=E | 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT<br><br>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that 4 of 28 | F 458 | | |

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| F 458 | Continued From page 37<br>resident rooms (Rooms 22, 23, 24, 25) met the square footage of 80 square feet (sq. ft.) per residents in multiple resident rooms.<br><br>Findings:<br><br>On January 8, 2013 at 8:10 a.m., during the entrance conference, while conducting a re-certification survey of the facility, the director of nursing (DON) was interviewed regarding facility rooms with less square footage than required. The DON stated that a room waiver would be submitted for resident rooms which did not meet the minimum requirement of 80 sq. ft. per residents in multiple resident rooms.<br><br>On January 8, 2013, at 10:30 a.m., the surveyor reviewed the room waiver request presented by the administrator below:<br><br>Room — Beds per Room — Sq. Ft.<br>22 — 2 — 117.2<br>23 — 2 — 105.78<br>24 — 2 — 106.77<br>25 — 2 — 115.95<br><br>Further review of the facility's survey file revealed that a decision was reached to deny a similar resident room size waiver request presented to Department of Health and Human Services, Centers for Medicare and Medicaid Services on May 25, 2012.<br><br>The minimum square footage for 2-bed rooms is 160 sq. ft., 4-bed rooms is 320 sq. ft.<br><br>On January 9, 2012, at 8:05 a.m., during a general observation, the above mentioned | F 458 | Preventing Reoccurrence:<br>The facility will take measures to ensure the residents in Rooms 22, 23, 24, 25 continue to not be adversely affected in health and safety.<br><br>This will be monitored daily via rounds by Department Managers, Administrator, DON, and/or Charge Nurses.<br><br>The CQI Committee and Safety Committee will monitor and follow up monthly as needed.<br><br>Monitoring Process:<br>Monitoring will be accomplished by Department Managers, Administrator, DON, Charge Nurses and Safety Committee via rounds. | |

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| F 458 | Continued From page 38<br>resident rooms were observed with beds and side dressers. The residents in these rooms have psychiatric diagnoses with behavioral problems and rooms appeared much smaller than most of the other rooms in the facility. The rooms size requirement does not appear to be in accordance with the special needs of the residents and may adversely affect the health and safety of the residents. | F 458 | Immediate Correction:<br>1. The two window screens were re-secured to the windows in Room 25 on 1/9/13 by Maintenance<br>2. The east wing toilet #3, stall #2 had missing tiles replaced and the stall partition was re-secured to the floor on 2/1/13 by Maintenance.<br>3. The west wing toilet #3 door knob was replaced on 1/9/13 by Maintenance<br><br>Others at Risk:<br>All window screens were checked for proper placement on windows and corrected as needed, all bathroom tiles were inspected and tiles replaced as missing, all bathroom stall partitions were reviewed for secure fastening to floors and re-secured as needed, all toilet door knobs were check for proper functioning and no other knobs needed replacement.<br><br>An in-service was given to Maintenance on 2/1/13 by Administrator regarding maintaining secured screens on windows, replacing missing tiles as needed and ensuring bathroom partitions are secure to the floor, and replacing non functioning door knobs timely. | 2/12/13 |
| F 465 SS=E | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide a safe and sanitary environment for the residents by ensuring:<br><br>1. Two window screens (approximately 60 inches in length by 24 inches in width) for Room 25 and 31 were installed.<br><br>2. The east wing toilet #3, stall #2 was missing tiles on the south wall and on the floor (approximately 24 inches in length by 12 inches in width). The stall partition was loose.<br>3. The west wing toilet #3, door knob was loose, hard to open and locked unintentionally.<br><br>Findings:<br><br>On January 9, 2013 at 8:25 a.m., during a | F 465 | | |

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| F 465 | Continued From page 39<br>general observation with the maintenance supervisor, the surveyor observed the following:<br><br>1. Two window screens for Room 25 and 31 were not properly installed on the window, and instead were stored between the resident's bed and the window.<br><br>2. The east wing toilet #3 stall #2 was missing tiles on the south wall and on the floor and the stall partition was loose because the bottom of the panel and pilaster were not fastened to the floor.<br><br>3. The west wing toilet #3 door knob was loose and when maintenance supervisor and surveyor attempted to exit the restroom the door would not open due to the loose door knob and the door locked unintentionally.<br><br>During an interview with the maintenance supervisor on January 9, 2013 at 9:20 a.m., regarding the conditions for the window screens, east wing toilet #3, and west wing toilet #3, the maintenance supervisor was informed that these conditions could cause a hazard for the residents. During this interview, the maintenance supervisor stated he would repair the unsafe areas, as soon as possible. | F 465 | Preventing Reoccurrence:<br>Maintenance will make rounds daily to inspect window screens, ensure tiles are repaired and partitions are secure in bathrooms, and door knobs are repaired or replaced for safety.<br><br>Administrator, Department Managers, and/or Charge Nurses will make daily rounds to ensure Maintenance has corrected all safety issues with window screens, floor tiles, bathroom partitions, and door knobs in a timely manner.<br><br>Safety Committee will provide monthly safety rounds and will notify maintenance for prompt attention to any needs for window screens, floor tiles, bathroom partitions, and door knobs.<br><br>Monitoring Process:<br>Monitored by Maintenance, Administrator, Department Managers, Charge Nurses in daily rounds. Safety Committee on monthly rounds. | |