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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056300	A. BUILDING _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANADA REHABILITATION & WELLNESS CENTER, LP	2885 HARRIS STREET EUREKA, CA 95503

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an annual recertification survey. Representing the California Department of Public Health, Health Facilities Evaluator Nurses 28786, 27568, 29797, and 39792. The facility census on the date of entry, 2/25/19, was 84. There were 18 sampled residents.	F 000	**Preparation, submission and/or execution of this plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.**	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604	F-TAG: 604 483.21 (b)(3)(i) Corrective action for residents affected by the deviant practice. Resident #11 was reassessed for elopement risk on 2/28/19 and again on 4/16/16 utilizing the Elopement Risk Assessment Policy No.-AP-17, in which a total score of 8 or greater indicates the resident should be considered at Risk for Potential Elopement. The result of both assessments resulted in a score of 10, indicating that resident #11 remains at risk of elopement; therefore the Wander guard placement is determined by the Interdisciplinary Team (IDT), to be a necessary intervention.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 4-22-19

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.

POC Accepted 5/6/19 @ 8.52 a.m.
Phoned to Administrator.
A Morales HFEA

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GRANADA REHABILITATION & WELLNESS CENTER, LP	2886 HARRIS STREET EUREKA, CA 95503

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F 604	Continued From page 1 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to ensure that the care plan and use of a wander guard, for one of 18 sampled resident's, Resident 11, was reassessed as necessary for use. This failure resulted in Resident 11, not attempting to leave the facility for over a year as per facility documentation, having a wander guard attached to her wheel chair for over a year, and failure of the Interdisciplinary Team (IDT) to consider a less restrictive approach. This failure had the potential to negatively affect Resident 11's dignity and for the facility to continue to require Resident 11 to have a wander guard instead of effective staff monitoring of Resident 11's whereabouts. Findings: A review of Resident's 11's quarterly MDS (Minimum Data Set - an assessment tool for a nursing home resident,), dated 11/21/18 indicated Resident had multiple diagnoses which included dementia. The MDS, section G, indicated Resident 11 was chair bound and required extensive assistance with moving around the facility in the wheel chair. Section E, under behaviors, indicated Resident 11 did not exhibit elopement behavior. Resident 11's February 2019 orders indicated an order for a wander guard "to	F 604	Corrective action for other residents with potential to be affected by the deviant practice. Residents with wander guard placement have potential to be affected by the deviant practice. The IDT met on 4/15/19 to review each of the residents with current orders for Wander guards and each of those residents will be reassessed by DON or designee for current elopement risk and appropriateness of continued Wander Guard placement. Measures put into place to prevent reoccurrence. Licensed Nurses (LN's) educated on performing a thorough Elopement Risk Assessment upon admission, readmission, quarterly, and with change of condition, by the DON on 4/19/19. Monitoring to assure sustained compliance. The DON or ADON will audit Elopement Risk assessments with monthly for 3 months and until substantial compliance is obtained. Results will be brought to monthly QAA meeting for review. Corrective Action Date: May 2, 2019	5/2/19

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F 604	Continued From page 2 wheel chair for unsafe exit seeking", initiated 10/6/17. During an observation on 2/27/19 at 9 a.m. Resident 11 was sitting in a high back wheel chair near the nurse's station, with breakfast on a bedside table. A wander guard alarm was attached to the back of her wheel chair. During an interview on 2/27/19 at 11:09 a.m. the Director of Nursing (DON) stated that Resident 11 was mobile in her wheel chair by pulling herself around via the hall rails. The DON stated Resident 11 did not use her feet to propel herself in the wheel chair. The DON stated Resident 11 had pushed the outside door open in the past and stated Resident 11 could not go over the door threshold because the wheel chair would get stuck on it. The DON stated she had asked Resident 11 in the past where she was going and Resident 11 responded that she did not know what she was doing. When asked where in Resident 11's chart was the documentation that Resident 11 attempted to leave the facility, the DON stated the only documentation was a 10/6/17, a nurse note at 3:30 where Resident 11 unsafely exited and was escorted back in. The DON stated there were no other attempts at exiting the building documented. During an interview and concurrent review of Resident 11's quarterly Elopement Risk Assessments, on 1/17/19 at 11:09 a.m., when asked if the Elopement Assessments were accurate the DON stated "maybe". A review of Resident 11's quarterly Elopement Risk Assessments, dated 3/12/18, 6/6/18, 8/29/18	F 604		

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F 604	Continued From page 3 and 12/4/18 indicated the resident was intermittently confused and was wheel chair bound and could wheel herself but needed assistance. A score of eight or greater indicated a resident was "at risk for potential elopement". Resident 11 was scored at "6" for all the assessments. The Elopement Risk Assessments indicated resident had no attempts at leaving for the past months and no elopement behaviors. Each assessment document included a section, "IDT Recommended Interventions". Each of the quarterly Elopement Risk Assessments indicated the section was blank; no recommendations were indicated.	F 604		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review the facility staff failed to accurately document the administration, use, and effectiveness of one of 18 sampled resident's, Resident 64's as needed pain medications, Norco 5/325 and Norco 10/325 (opioid pain medications of different dosages -both Schedule II drugs) in Resident 64's Medication Administration Record (MAR). This failure resulted in an inaccurate assessment of Resident 64's use and effectiveness of the opioid pain medication and had the potential that Resident 64's pain would not be relieved or Resident 64 would receive unnecessary medication.	F 658	F-TAG: 658 483.21(b)(3)(i) Corrective action for residents affected by the deviant practice. Resident #64 discharged from the facility on 3/9/19. Corrective action for other residents with potential to be affected by the deviant practice. The Nursing Supervisor will audit the documentation of residents administered pain medication and provide the information to the DON for LN training needs by 4/21/19 Measures put into place to prevent reoccurrence.	

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F 658	Continued From page 4 (Schedule II medications are controlled substances under the Controlled Substances Act, Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. Schedule II drugs have a high potential for abuse which may lead to severe psychological or physical dependence). Findings: A review of Resident 64's February 2019 Physician Orders indicated Resident 64 was diagnosed and treated for aftercare following joint replacement surgery of the right hip. Resident 64 was prescribed Norco 5-325, on tablet every six hours as needed for moderate pain indicated as 4-7 out of 10 on the pain scale, and prescribed Norco 10/325 one tablet every six hours as needed for severe pain indicated as 8-10 out of 10, and Tylenol 650 for mild pain 1-3/10 every six hours as needed. Resident 64's orders indicated to monitor Resident 64's pain level. Resident 64's care plan, initiated 2/1/19, indicated staff were to assess the resident's level of pain "using pain rating scale 1-10". During an observation and interview on 2/26/19 at 3:16 p.m., Resident 64, out on the smoking patio, indicated her recent hip surgery and therapy. Resident 64 stated that she was treated for pain but that it was not always enough and she experienced pain before therapy. A review of Resident 64's February 2019 MAR -through 2/25/19 - indicated separate entries for the two different opiates, Norco 5/325 for moderate pain and Norco 10/325 for severe pain, and an entry for Tylenol 650 mg as needed every	F 658	All residents have the potential to be affected by the deviant practice. LNs were in-service via written Memo with attached policy and procedure (P&P) PA-02 "Administration of Pain Medication", and attached P&P PA-01 "Pain Assessment" on 2/28/19. These two P&P's review the requirement to utilize the 0-10 pain intensity scale when assessing, re-assessing, and documenting all pain assessment findings. LN's will be in-serviced again on 4/19/19 on utilizing the 0-10 pain intensity scale in assessing, reassessing, and documenting pain and pain medication administration, as well as the need for accuracy in documentation. Monitoring to assure sustained compliance. The DON and/or ADON will audit pain medication documentation weekly for 3 months and until substantial compliance is obtained. Results will be brought to monthly QAA meeting for review. Corrective Action Date: May 2, 2019	5/2/19

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F 658	Continued From page 5 six hours for mild pain. The MAR indicated Resident 64 was not administered Tylenol 650. Resident 64's February MAR -through 2/25/19 - indicated Resident 64 was administered as needed Norco 5/325 once on four different days, and was administered Norco 5/325 twice on three different days, for a total of 10 times. The backside of the February MAR indicated Norco 5/325 was given a total of 16 times. The data from the front of the MAR did not match the data documented on the backside of the MAR. Resident 64's February MAR -through 2/25/19 - indicated Resident 64 was administered as needed Norco 10/325 39 times. The backside of the February MAR indicated Norco 10/325 was given a total of 31 times. Resident 64's February MAR -through 2/25/19 - indicated Resident 64 was administered a dose of Norco 49 times. The backside of the MAR indicated documentation for Norco 47 times. A review of Resident 64's February 2019 MAR indicated multiple instances where the nursing standard of practice of documenting a resident's pain level was not done on 16 different instances. Nursing staff did not document Resident 64's pain level on three different instances on 2/2/19, two different times on 2/5/19, once on 2/6/19, once for the entry date logged right after 2/19/19 (which was illegible), twice on 2/22/19, twice on 2/23/19, three times on 2/25/19, and one time on 2/26/19. During an interview and concurrent review of Resident 64's February 2019 MAR, the Director of Nursing (DON) stated that licensed nursing staff did not follow the nursing standards of	F 658		

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F 658	Continued From page 6 practice or facility policy regarding MAR documentation. The DON acknowledged that the fact Resident 64's physician's orders defined the parameters under which Norco 5/325 and Norco 10/325, were to be given combined with the lack of documentation of describing Resident 64's pain level, there also was a problem as to whether the resident received the correct dose, per physician orders. The DON stated that nursing staff needed to be re-trained.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide 3 of 16 sampled residents of (Residents 54, 37 and 18) scheduled weekly showers. This resulted in residents looking unkempt and had the potential to negatively impact the resident's physical and psychosocial wellbeing. Findings: 1. During a review of Resident 54's history and physical dated 1/23/19, indicated he had encephalopathy (a disease of the brain that results in damage or malfunction causing changes in mental status) and the plan was for long term care. Resident 54's Quarterly MDSs (minimum data set, a clinical process providing a comprehensive assessment of the resident's	F 677	F-TAG: 677 483.24 (a)(2) Corrective action for residents affected by the deviant practice. • Resident #37 discharged from the facility on 3/9/19. • Resident #54 is scheduled showers on Tuesdays and Saturdays. Per current documentation he has been showered on last 5 scheduled shower days: 4/2/19; 4/6/19; 4/9/19; 4/13/19; 4/16/19. • Resident #54 was a logger in his younger years and prefers a rugged looking, long beard. The facility has offered to have his hair and beard trimmed if he desires. • Resident #18 is scheduled showers on Tuesdays and Saturdays. Per current documentation she has been showered on last 4 scheduled shower days: 4/6/19; 4/9/19;	

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F 677	Continued From page 7 functional capabilities which helps staff identify health problems) dated 1/31/19; indicated Resident 54's cognitive skills (core skills your brain uses to think, read, learn, remember, reason and pay attention for daily decision making) were severely impaired (never, rarely made decisions), and he needed one person maximum physical assistance for ambulating and maximum assistance with hygiene activities (combing hair, showering, shaving, brushing teeth and ambulating). During an interview and concurrent observations on 2/26/19 at 8:54 a.m. Resident 54 indicated he was not aware of how often he has showers at the facility nor could he recall the day of the week he usually showers. Resident 54 was observed to sitting up in bed, dressed in regular clothes, his hair looked greasy, his beard growth was past his chin and looked straggly. During a review of Resident 54's plan of care for ADLs (Activities of Daily Living): daily self-care activities... Common ADLs included personal hygiene and bathing, initiated on 12/30/18 indicated he needed assistance with ADL functions by breaking tasks into manageable segments. A review of Resident 54's shower schedule indicated he had Tuesdays and Saturdays as assigned days to shower. A review of the Facility ADL Flowsheet for the month of February (days 1-27) indicated Resident 54 had 3 (1/2/19, 1/12/19 and 1/19/19) out of 8 scheduled shower opportunities. During an interview on 2/27/19 at with Unlicensed Staff E, she stated her role at the facility was to fill	F 677	4/13/19; 4/16/19. Resident #18 has a long history of mental illness and usually gets upset when offered to trim her long thin hair. The facility has offered to have her hair trimmed if she desires. Corrective action for other residents with potential to be affected by the deviant practice. The Assistant Director of Nurses (ADON) did a facility shower audit 4/16/19 and 4/17/19. The ADON has re-typed the shower schedules for clarity, and will meet with care staff to update the shower schedule so it is manageable in terms of work-flow. Measures put into place to prevent reoccurrence. All residents have the potential to be affected by the deviant practice. The Director of Staff Development (DSD) will provide in-service training to the Certified Nursing Assistants (C.N.A.'s) on showers and shower documentation on 4/22/19. The ADON is developing a shower check-off tool for the Charge Nurses to track the scheduled showers and to track the documentation of the showers each shift for better compliance with both the showers and	

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F 677	Continued From page 8 in where needed and indicated she did not know Resident 54's shower schedule. 2. During a review of Resident 18's Admission Assessment dated 6/6/14 indicated she had diabetes mellitus (A chronic condition that affects the way the body processes sugar in the blood), mental impairment (mind is damaged resulting in learning disabilities), congestive heart failure (a chronic condition in which the heart doesn't pump blood throughout the body as well as it should) and a pacemaker. Resident 18 was admitted to the facility on 9/13/02 as a long term care resident. During an observation on 2/25/19 at 10:57 a.m. with Resident 18, she was dressed in her wheelchair and in the activity room playing a game with staff assistance. Resident 18's hair look greasy and uncombed. Resident 18 could not be interviewed due to her mental condition. Resident 18 's Quarterly MDSs (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) dated 12/1/18, indicated she could not participate in her cognitive interview, she was assessed to be totally dependent on staff for showers and overall hygiene. A review of Resident 18's Plan of Care dated 12/30/18 indicated she required assistance and adaptive equipment for bathing/showers. A updated review of Resident 18's Plan of Care dated 1/28/19 indicated she had impaired mobility, incontinence and thin fragile skin.	F 677	the documentation of the showers. The LN's will be notified of the upcoming check-off tool at the 4/19/19 Licensed Nurses In-Service, and will be trained on the tool when it is implemented 4/22/19. Monitoring to assure sustained compliance. The DON and/or designee will audit resident showers weekly for compliance of the shower schedule and shower documentation for 3 months and until substantial compliance is obtained. Results will be brought to monthly QAA meeting for review. Corrective Action Date: May 2, 2019	5/2/19

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F 677	Continued From page 9 A review of Resident 18's shower schedule indicted she was assigned to have a shower on Tuesdays and Saturdays. A review of Resident 18's shower record date 01/19 indicated she had 6 (1/1/19, 1/5/19, 1/8/19, 1/16/19 and 1/29/19) showers out of 9 scheduled shower opportunities. A review of Resident 18's shower record dated 02/19 indicated she had a total of 4 showers (2/2/19, 2/9/19, 2/19/19 and 2/23/19) out of 8 scheduled shower opportunities.	F 677		
F 761 SS=B	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	F-TAG: 761 Corrective action for residents affected by the deviant practice. No resident was affected by this deviant process. The expired vial of tuberculin solution was discarded 2/27/19. Corrective action for other residents with potential to be affected by the deviant practice. The DON rechecked both medication refrigerators for expired items 3/1/19 and no expired items were found. Measures put into place to prevent reoccurrence. All residents have the potential to be affected by the deviant practice. The DON has audited the facility	

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F 761	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to discard one vial of tuberculin solution when it had been opened for more than one month. The failure had the potential to cause a resident to receive an inaccurate test for tuberculosis. An inaccurate test for tuberculosis had the potential to result in a delay of necessary treatment for a resident who had the disease. Findings: During an observation with concurrent interview on 2/27/19 at 10:30 a.m. in the Medication Room of Nurses Station 1, one vial of tuberculin solution, a combination of proteins from the bacteria that causes tuberculosis that is used to test a person for the active disease, had been opened on 11/31/18 and had not been discarded after one month of use per the instuctions on the vial. The Regional Quality Consultant stated that the vial should have been discarded one month after it was opened. The Regional Quality Consultant removed the vial of tuberculin from the refrigerator in the Medication Room of Nurses Station 1. During a review of facility policies on 2/27/19, the facility policy titled Disposal/Destruction of Expired or Discontinued Medication effective date 12/1/07 indicated that the facility should destroy discontinued or out-dated non-controlled medications by one of two methods. There was nothing in the policy that addressed the discontinuation of an opened tuberculin vial after one month of use.	F 761	medication refrigerators weekly since survey and as of 4/16/19 added a weekly random audit of medication storage areas other than the refrigerators. The DON will in-service the Licensed Nurses at the scheduled 4/19/19 Licensed Nurses meeting on the process of removing expired/outdated medications from medication storage areas and in-service on the process of medication destruction. Monitoring to assure sustained compliance. The DON and/or designee will audit medication storage areas with focus on the medication refrigerators for 3 months and until substantial compliance is obtained. Results will be brought to monthly QAA meeting for review. Corrective Action Date: May 2, 2019	5/2/19

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F 773 F 773 SS=D	Continued From page 11 Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review the facility to ensure one of 18 sampled resident's, Resident 11's, abnormal non-fasting glucose level was reported to Resident 11's physician as per facility policy. This failure resulted in Resident 11's high non-fasting glucose level not being reported and addressed as a potential concern by nursing and medical staff. Findings: A review of Resident 11's February 2019 physician orders indicated the resident had multiple diagnoses which included schizophrenia disorder (a mental disease,) depression, and chronic anemia. Resident 11 was on a mechanical soft diet. A review of Resident 11's most recent lab results, collected 10/5/18, indicated the resident had a non-fasting blood sugar level of 185, which was high with the normal reference range between 70-126 mg/dL.	F 773 F 773	F-TAG: 773 Corrective action for residents affected by the deviant practice. Dr. Dheeriya was the physician who originally signed off the laboratory result indicating a non-fasting serum glucose level of 185 for Resident 11, while the primary physician for Resident 11, Dr. Lei Han, was out of town. On 2/27/19 Dr. Han was notified of the elevated serum glucose and an HbA1c (glycated hemoglobin test) was requested by the DON. Dr. Han told the DON that an HgA1c was not indicated, nor was any further follow-up indicated. On 3/19/19 Dr. Han wrote a progress note in the medical record of Resident 11 to explain her decision. Corrective action for other residents with potential to be affected by the deviant practice. An informal review of laboratory results that have been signed off by Physicians and Nurse Practitioners finds that they often just sign their name or initials, sometimes without a date. This issue was discussed by the IDT at the 4/16/19 QAA meeting which was attended by both Dr. Dheeriya and Dr. Han. Dr. Dheeriya	

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F 773	Continued From page 12 (milligrams per deciliter). Resident 11's physician orders included two medications that had the potential to increase the blood sugar levels, Risperdal 1 mg, twice daily and Propranolol, a heart medication, 10 mg twice daily. A review of Resident 11's Interdisciplinary Notes and nursing notes with the Director of Nursing (DON) on 2/27/19 did not indicate that Resident 11's abnormal non-fasting blood sugar level was followed-up with a discussion with the physician or a repeat lab was considered. During an interview and concurrent record review with the DON and Registered Dietician (RD) on 2/27/19 in the afternoon, the DON stated that there was an initial at the bottom of Resident 11's 10/5/18 lab result. The DON stated she did not know which physician or nurse practitioner from the contracted physician's group initialed the document (the initial did not include a date). When asked whether nursing contacted the physician regarding the abnormal lab result, the DON stated she could call the physician's group to clarify for any follow-up. The RD stated that she had not seen Resident 11 yet and stated that she did not know if the lab indicated a concern or not. The RD stated she was going to request an order for HbA1c (glycated hemoglobin test - a blood test which measures the average level of blood sugar over a 2-3 month time period) in order to find out whether this was a one time finding and to rule out a new chronic condition. A review of the facility policy Laboratory Services, revised 1/1/12, indicated the licensed nurse was to notify the attending physician of the abnormal results via telephone and fax the attending physician with the date and time noted on the	F 773	requests the facility stamp the laboratory results with a check-box option "No further order" to make that direction clear. Measures put into place to prevent reoccurrence. All residents have the potential to be affected by the deviant practice. The DON will facilitate the acquisition of stamps for LNs to use to print on the incoming laboratory results a prompt to the practitioners to both sign and date the laboratory result when they have reviewed it; and also a box to check if there is no further order, to make that direction formal as opposed to implied. The process of stamping the laboratory results will begin when the stamps arrive to the facility, as they are being ordered. The DON will in-service the Licensed Nurses at the scheduled 4/19/19 Licensed Nurses meeting on the process using the stamp on the laboratory results. At the 4/19/19 nurses meeting the DON will also discuss with the Licensed Nurses the need to question the practitioners about abnormal results that may indicate a change of condition for the resident and use of nursing documentation to track these interactions.	

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F 773	Continued From page 13 results. The nurse "documents the time when the laboratory results were reported along with the attending physician response in the resident's medical record."	F 773	Monitoring to assure sustained compliance. The DON and/or designee will audit laboratory result follow-up for 3 months and until substantial compliance is obtained. Results will be brought to monthly QAA meeting for review. Corrective Action Date: May 2, 2019	5/2/19
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791	F 791 483.55 (b)(1)-(1) Routine/Emergency Dental Srvcs in NFs Corrective action for residents affected by the deviant practice. • Resident # 33 was seen by the Dentist on 4/8/19 at the PACE program by Dr. Nelson. • Resident #18 will be seen by Oral Healthcare in Facility on their visit in May 2019. Corrective action for other residents with potential to be affected by the deviant practice. Residents in the facility could be affected therefore; the Administrator reeducated the Social Services Director on the importance of the facility policy	

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F 791	Continued From page 14 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to implement a system for long term residents to have annual dental exams/teeth cleaning and for a newly admitted resident to be evaluated by a dental consult within a reasonable timeframe. Residents 18 was not assisted in obtaining annual dental exam/ teeth cleaning during a routine visit conducted on 7/9/18 resulting not having a dental exam or teeth cleaning for the year 2018. Resident 33 had requested dental services due to her a problem with her upper denture. This had the potential for increased infections within the mouth, infections within the heart, pain, tooth decay and loss of natural teeth. 1. During a review of Resident 18's Admission Assessment dated 6/5/14 indicated she had diabetes mellitus (A chronic condition that affects the way the body processes sugar in the blood), mental impairment (mind is damaged resulting in learning disabilities), congestive heart failure (a chronic condition in which the heart doesn't pump blood throughout the body as well as it should), mitral stenosis (a valve in the heart that does not function appropriately) and a pacemaker. Resident 18 was admitted to the facility on	F 791	and procedure for Oral Healthcare and Dental Services on 4/19/19. The facility implement a system for long term resident to have annual dental exam/teeth cleaning and to assist residents in obtaining routine preventative care and 24-hour emergency dental care. Measures put into place to prevent reoccurrence. During Daily Stand Up Meeting, IDT will discuss any residents who are having dental issues and will follow up with Social Service Director on plan of care for any dental services needed. Social Services Director developed an appointment log to track dental care. Social Service Director will make a referral for dental service as applicable per resident and responsible party wishes. How the facility plans to monitor the performance to make sure solutions are sustained: Social Service will discuss any issues with Dental Services during the monthly QA &A Meeting discussion will continue for the next 3 months and or until substantial compliance is met and sustained or new recommendations will be made and	

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F 791	Continued From page 15 9/13/02 as a long term care resident. During an observation on 2/25/19 at 12:32 a.m. with Resident 18, she was dressed, sitting in her wheelchair in the dining room being fed by staff during lunch. Resident 18 was observed to not have all of her teeth as evidenced by gaps of missing teeth. Resident 18 's Quarterly MDSs (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) dated 12/1/18, indicated she could not participate in her cognitive interview, she was assessed to be totally dependant on staff for eating and overall hygiene including brushing her teeth. A review of Resident 18's Plan of Care dated 1/29/19 indicated she required assistance with mouth care due to missing teeth. During a review of the clinical record dated 6/21/17 indicated Resident 18 had a dental exam. During a concurrent interview and record review with DSD, dated 6/25/19 at 1:16 p.m. indicated a visit from Oral Health Care was made to the facility on 7/9/18 and Resident 18 as per the document was not on the list to be seen. The DSD could not explain why Resident 18 was not on the list to be seen and was not aware of her heart condition. When the DSD was asked regarding the next dental visit, she stated she was not sure initially stating it would be in six months.and when reminded of the date, 2/25/19 she changed her answer to every year. The DSD explained the process as she would create a list	F 791	acted upon by the Medical Director and Administrator. Corrective Action Date: May 2, 2019	5/2/19

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F 791	Continued From page 16 of residents to be seen and would then contact Oral Health to schedule a visit to the facility. 2. During a review of the clinical record dated 12/18/18, Resident 33 was admitted to the facility on 9/26/18 from the hospital status post hardware removal from her knee due to infection, antibiotic administration therapy through a peripherally inserted intravenous catheter and rehabilitation. Resident 33's Admission Assessment MDS (minimum data set, clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) dated 10/31/18 indicated she cognitive ability to participate in her plan of care and able to verbalize her needs. A review of the Dental/Oral Assessment dated 12/18/18 indicated Resident 33 had broken and missing teeth. The Resident Care Plan for Dental Care dated 12/18/18 indicated she would be monitored for oral pain or discomfort. During an interview dated 2/26/19 with Resident 33 she stated she needs to have an upper plate (denture for the top of layer of teeth) and had requested to be seen by a dentist. Resident 33 stated she had not been seen by a dentist due to her recent health problems (infections in her knee replacement prosthesis) and was having pain in her upper jaw area. Resident 33 could not state who she told, but stated it was one of the many people she spoke with when she first arrived at the facility. During an interview with SSD dated 2/27/18 at 8:49 a.m. she stated Resident 33 had missed the dental consult that was conducted on 7/9/18 and	F 791		

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F 791	Continued From page 17 she was not aware of the pain of the upper jaw. The DSD stated she would not make an appointment with the dental hygienist or Dentist if she was not aware of the problem but would now that she knew. The DSD stated it was not a dental emergency so Resident 33 would placed on a list to be seen during the next dental visit. The DSD indicated during the interview a list would be created just prior to scheduling a visit with Oral Health Care to come and visit the facility. The facility policy and procedure titled, " Oral Healthcare and Dental Services", revised on 7/14/17, indicated "Dental Services...The routine dental care provided to residents includes:...preventative care and treatment...The Social Services Staff/designee is responsible for assisting with arranging necessary dental appointments..."	F 791		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to ensure food prepared for the residents was palatable (pleasant tasting) when residents complained	F 804	F804 60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Corrective action for residents affected by the deviant practice. Residents identified during time of survey with concerns with food related concerns have been interviewed to clarify specific complaints and update food preferences as indicated. Resident #4 was immediately provided with a second grilled cheese sandwich which she ate and enjoyed.	

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F 804	Continued From page 18 about the food and Resident 4 complained that a lunch substitute, grilled cheese, was burnt. A test tray revealed that the pureed au gratin potatoes was not palatable. This failure had the potential that facility residents would not eat or would eat less than their dietary requirements, and that the seven residents on a pureed textured diet would not consume the food item, which could result in facility residents not maintaining an optimum level of physical health and well-being. Findings: On 2/25/19 thru 2/26/19, during the initial walk thru and greeting of residents by the Surveyors, residents had complaints about the taste of the food. During an interview on 2/25/19 at 9:51 Resident 32 stated "the food could be better." She stated the green beans, peas, and spinach "are not cooked right." On 2/25/19 at 9:45 a.m., Resident 53 stated she disliked the breakfast. Resident 79 stated she used to be a cook and stated she did not like the food at the facility. On 2/25/19 at 10:00 a.m., Resident 56 stated the food was usually very bland, stated 1 out of 5 meals was not good, rice dishes were dry and not palatable, the chicken is tough, and the food temperature was not hot but warm or cold. Resident 66 stated that sometimes food preferences were ignored. On 2/25/19 at 11:00 a.m., Resident 66 had general complaints about the palatability of the	F 804	Corrective action for other residents with potential to be affected by the deviant practice. Residents who eat meals in the facility have the potential to receive food that they perceive to be of unsatisfactory palatability or do not coincide with individual food preferences. Residents are interviewed for food preferences at time of admission, quarterly, and as needed. Individual resident diet profiles include food likes and dislikes and are updated as needed. Monthly resident council meetings offer residents the opportunity to voice food related concerns which are then followed up with by the Dietary Manager and/or Dietitian for resolution. Dietary employees have been re-educated on following residents' listed food preferences by the Dietitian and Food Service Supervisor on 4/22/19. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur: Prior to the time of survey, the facility identified concerns relating to food complaints based on review of resident council minutes and individual resident interviews. The facility developed a QAPI to address food	

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F 804	Continued From page 19 food. On 2/27/19 at 1:17 p.m., a lunch meal, with regular, mechanical soft, and pureed textured food was tested for temperature and palatability. The pureed au gratin potatoes tasted under seasoned and pasty. The Dietary Services Supervisor and Registered Dietician were non-committal in their comment about the palatability of the pureed au gratin potatoes. A second Surveyor stated the pureed au gratin potatoes tasted gluey. During a review of Resident 4's record on 2/25/19, the Physician's Order Summary for February 2019 indicated that Resident 4 was on a mechanical soft diet with thin liquids. During an observation 2/25/19 at 1:00 p.m., Resident 4's grilled cheese sandwich had patches of a black substance on the outer side of one piece of bread which Resident 4 was able to partially scrape off with her spoon. During an observation and concurrent interview on 2/25/19 at 1:00 p.m., Resident 4 stated that she was not able to eat the grilled cheese sandwich that she got with the regular lunch entree because it was burned on one side and too tough to eat. Resident 4 stated that she got a grilled cheese sandwich with lunch and dinner but was usually not able to eat it because it was burned on one side and too tough to eat. Resident 4 stated that she had no teeth and the regular menu items were too difficult for her to eat. The white paper on Resident 4's lunch tray, the tray card, indicated that she was on a regular mechanical soft diet.	F 804	complaints. Menu/food meetings held with residents every other week for 2 months. Findings reviewed by the Dietary Manager, Registered Dietitian, and Activities Director and results communicated to the Administrator. Test trays were conducted three times weekly for taste, temperature, and overall palatability for a total of 4 weeks. Will conduct test trays focusing on puree texture and grilled cheese sandwiches at least twice weekly for 4 weeks and then at least once weekly for a total of 3 months. How the facility plans to monitor the performance to make sure solutions are sustained: The Dietary Manager and Registered Dietitian will review the results of test tray audits weekly for 4 weeks and then monthly for 3 months. Findings will be reported during monthly CQI meetings for 3 months. Staff will conduct at least 3 random resident meal satisfaction interviews weekly for 4 weeks and then at least 5 random resident meal satisfaction interviews monthly for 3 months. Findings will be reported during monthly CQI meetings for 3 months. The Dietary Manager and/or Registered Dietitian will conduct random tray line audits focusing on compliance with food preferences at least twice weekly for 4 weeks and then at least once per week	

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F 804	Continued From page 20. During an interview with the Food Service Director at the bedside of Resident 4 on 2/25/19 at 1:20 p.m., when the Food Service Director observed Resident 4's grilled cheese sandwich, she stated" it is not burnt." The Food Service Director offered to get Resident 4 another grilled cheese sandwich. During an interview with Resident 4 on 2/25/19 at 3:00 p.m., Resident 4 stated that she received another grilled cheese sandwich, it was not burned or black on any side, she was able to eat it. During a review of facility policies on 2/27/19, the policy titled Resident Preference Interview, revised April 1, 2014 indicated that "The Dietary Department will provide residents with meals consistent with their preferences as indicated on the tray card. " There was no policy that specifically addressed the palatability of food items. Based on observation, interview, and record review, the facility did not provide a palatable substitute for the regular lunch menu item for one resident. The failure had the potential to cause the resident to not eat anything for lunch which had the potential to result in deficient intake. A deficiency in intake had the potential to prevent a resident from maintaining an optimum level of physical health and well being. Findings: During an observation and concurrent interview on 2/25/19 at 1:00 p.m., Resident 4 stated that she was not able to eat the grilled cheese sandwich that she got with the regular lunch entree because it was burned on one side and	F 804	for 3 months. Findings will be reported during monthly CQI meetings for 3 months. Corrective Action Date: May 2, 2019	5/2/19

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GRANADA REHABILITATION & WELLNESS CENTER, LP	2885 HARRIS STREET EUREKA, CA 95503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 21 too tough to eat. Resident 4 stated that she got a grilled cheese sandwich with lunch and dinner but was usually not able to eat it because it was burned on one side and too tough to eat. Resident 4 stated that she had no teeth and the regular menu items were too difficult for her to eat. The white paper on Resident 4's lunch tray, the tray card, indicated that she was on a regular mechanical soft diet. Resident 4's grilled cheese sandwich had patches of a black substance on the outer side of one piece of bread which Resident 4 was able to partially scrape off with her spoon. During an interview with the Food Service Director at the bedside of Resident 4 on 2/25/19 at 1:20 p.m., when the Food Service Director observed Resident 4's grilled cheese sandwich, she stated" it is not burnt." The Food Service Director offered to get Resident 4 another grilled cheese sandwich. During an interview with Resident 4 on 2/25/19 at 3:00 p.m., Resident 4 stated that she received another grilled cheese sandwich, it was not burned or black on any side, she was able to eat it, and it was good. During a review of Resident 4's record on 2/25/19, the Physician's Order Summary for February 2019 indicated that Resident 4 was on a mechanical soft diet with thin liquids. During a review of facility policies on 2/27/19, the policy titled Resident Preference Interview revised April 1, 2014 indicated that "The Dietary Department will provide residents with meals consistent with their preferences as indicated on the tray card. " There was no policy that	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056300	A. BUILDING _____ B. WING _____	02/28/2019

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F 804	Continued From page 22 specifically addressed the palatability of food items.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility failed to ensure the sanitizing solution used to wipe down kitchen surfaces was at the correct concentration in one of two red buckets. This failure had the potential that dietary staff would use the weak sanitizing solution to wipe the kitchen surfaces leaving the facility residents at risk that surfaces used to prepare food could harbor bacterial or other contaminants. Findings:	F 812	F812 483.60(i)(2) Food Procurement, Store/Prepare/Serve-Sanitary Corrective action for residents affected by the deviant practice. No residents were affected by the deficient practice. Corrective action for other residents with potential to be affected by the deviant practice. Residents in the facility have the potential to be affected by consuming food that may have come into contact with inadequately sanitized surfaces in the kitchen. Dietary employees received re-education on the importance of ensuring sanitizing solution is at an appropriate concentration to prevent food contamination on 2/28/19. In addition to documenting the concentration of sanitizing solution per shift, dietary employees will also check the solution prior to each use and will replace the sanitizing solution if concentration below acceptable range.	

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

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F 812	Continued From page 23 During an interview and observation with the Dietary Services Supervisor (DSS) on 2/28/19 at 9:30 a.m., there were two red buckets in the kitchen that contained ammonia based sanitizing solution and rags for cleaning kitchen surfaces. During an observation, Dietary Staff K placed a quaternary test paper strip in the solution of one of the red buckets. The test strip color, a yellow-green color indicated the solution was approximated at 100 parts per million when compared with the color coded chart on the test strip dispenser. The DSS stated, when asked, that the cleaning rags were fresh and had not yet been used. The DSS stated the solution in the red bucket was changed 45 minutes ago but the solution read on the low end. A review of the facility policy of use of quaternary ammonium testing procedure, undated, indicated the concentration of ammonia would be checked and recorded prior to use. The facility policy on quaternary ammonium log, undated, indicated the dietary aide would record the solution level in a log prior to sanitizing counters and washing pots daily to assure the level is at least 150 parts per million. During an interview on 2/28/19 at 12:06 p.m., the DSS said that the solution should be between 200 and 400 parts per million.	F 812	What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur: The Dietary Manager and/or Registered Dietitian will conduct random observations and employee interviews regarding compliance with testing sanitizing solution prior to use at least 3 times per week for 4 weeks and then at least once weekly for a total of 3 months or until 100% compliance achieved. How the facility plans to monitor the performance to make sure solutions are sustained: The Dietary Manager and Registered Dietitian will review the findings of compliance with testing of sanitizing solution for appropriate concentration to avoid food contamination weekly for 4 weeks and then monthly for a total of 3 months or until 100% compliance achieved. Results will be reported during monthly CQI meetings for 3 months. Corrective Action Date: May 2, 2019	5/2/19