Plan of correction received and approved by 07598

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FORM APPROVED
OMB NO. 0938-0391

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

HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING 2012 AUG 23 AM 10:09	04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

Royal

RECEIVED

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: 07598 09697 10115 Total resident Sample: 11 Total resident Population: 41 Highest Scope & severity= F	F 000	This plan of correction constitutes our written credible allegation of compliance for the deficiencies noted. This facility will be in substantial compliance no later than 6/17/12.	
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to obtain admission orders for each resident's immediate care for one of 11 sample residents (Resident 7). Resident 7 had a heparin lock (a device used to administer fluids intravenously) and was observed receiving oxygen. The clinical record contained no physician's order for the heparin lock or oxygen. Findings: On 4/26/12 at 7:35 p.m., during the initial tour, Resident 7 was observed in a reclining position asleep. The gastric (stomach) tube feeding,	F 271	It is the policy of Royal Garden Extended Care Hospital (RGECH) that at the time each resident is admitted, the facility must have physician orders for the resident's immediate care. • Licensed Nurse notify the attending physician of Resident 7 and ordered oxygen at 2 L/min via nasal cannula continuously for SOB and Treatment order for Heparin lock without physician's order. • All residents had the potential to be affected by this deficient practice. The in-servicing by DON to all licensed nurses on admission physician orders serves as corrective action for this deficient practice.	

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

ADMINISTRATOR 06-15-12

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 271	Continued From page 1 "Glucerna 1.2", was observed infusing at a rate of 30cc per hour into the resident's gastric feeding tube. An oxygen concentrator was observed at the resident's bedside, and the resident was receiving oxygen at a rate of 2 liters per minute via nasal cannula. According to the licensed nurse accompanying the surveyor, Resident 7 was bedridden. On 4/28/12 a review Resident 7's clinical record disclosed that the resident was admitted to the facility on 4/25/12, with diagnoses that included cellulitis of the foot and leg, attention to gastrostomy, and hypertension. The resident was newly admitted to the facility and the Minimum Data Set (MDS), a standardized assessment and care planning tool, had not yet been completed. On 4/28/12 the licensed nurse was observed to administer wound care to Resident 7. During the treatment observation the resident was observed to have a heparin lock in her left foot. On 4/28/12 further review of the clinical record for Resident 7, revealed no physician's orders for the heparin lock or the oxygen. On 4/28/12 during an interview with the director of nurses (DON) and a joint review of the resident's clinical record, the DON confirmed that the physician orders for the heparin lock and the oxygen had not yet been documented.	F 271	• The DON provided in-service to licensed nurses on policy and procedure of admission physician orders. The DON will assess new admission for any immediate care that requires a physician orders. Any deficient practices will be reviewed with the concerned licensed nurse for corrective action as needed. • DON will report her findings at the monthly Quality Assurance Meeting for evaluation, oversight, and action as needed. • Compliance date:	6/17/12
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278	It is the policy of RGECH that the assessment accurately reflects the resident's status.	

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F 278	Continued From page 2 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that all assessments accurately reflected the resident's status for two of 11 sample residents (Resident 4 and 7). Resident 7's assessment indicated the resident had edema to all extremities but gave no detail of how severe the edema was. Resident 4's bowel and bladder status assessment was inaccurate. Findings: a. On 4/28/12 at 7:35 p.m., during the initial tour, Resident 7 was observed in a reclining position	F 278	• A. Resident 7 was immediately reassessed of the edema and attending physician and responsible party was also notified. Edema was documented in the licensed nurse notes and licensed nurse will monitor the progress or decreasing of edema. B. Resident 4 was immediately reassessed and she is continent of bladder and bowel functions. Licensed nurse documented this assessment in the bowel and bladder assessments on 2/28/12. • All residents had the potential to be affected by this deficient practice. The in-servicing by DON to all licensed nurses on accurate assessment of bladder assessment and assessment of edema serves as corrective action for this deficient practice. • The DON provided in-service training to licensed nurses on accurate assessment of edema and bladder and bowel assessment. The DON will randomly assess residents for any signs and symptoms of edema and their bowel and bladder functions on a monthly basis.	

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F 278	Continued From page 3 asleep. According to the licensed nurse accompanying the surveyor, Resident 7 was bedridden. On 4/28/12 a review Resident 7's clinical record disclosed that the resident was admitted to the facility on 4/25/12, with diagnoses that included cellulitis of the foot and leg, attention to gastrostomy, and hypertension. The resident was newly admitted to the facility and the Minimum Data Set (MDS), a standardized assessment and care planning tool, had not yet been completed. On 4/28/12 at 11:15 a.m., the licensed nurse was observed to administer wound care to Resident 7. During the treatment observation the resident was observed to have severe edema of the left arm, hand, and fingers and had a mild to moderate amount of edema to the left hand. The resident was also observed to have severe edema of the right foot and a mild amount of edema to the left foot, where the resident had a heparin lock in place. On 4/28/12 further review of the clinical record for Resident 7 revealed an admission assessment dated 4/25/12, indicating that the resident had edema to both upper and lower extremities. There was no further documentation to indicate the type of edema the resident had and how severe the edema was in order to monitor the edema and notify the physician if the patient's status of edema declined, improved, or stayed the same. On 4/28/12 during a review of the facility's policy entitled, "Edema" indicated that it is the policy of the facility to assess the resident for any signs of accumulation of fluids in their body such as in the upper or lower extremities and abdomen. The	F 278	• The DON will report her findings at the monthly Quality Assurance Meeting for evaluation, oversight, and action as needed. • Compliance date:	6/17/12

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F 278	Continued From page 4 licensed nurse will measure edema on a daily basis, preferable same time for consistency and record results to licensed notes or form provided. Results will be relayed to attending physician for further intervention. On 4/28/12 at 12/24/12, during an interview with the director of nurses (DON) and a joint review of the resident's clinical record, the DON indicated that the assessment for edema should reflect how severe the edema is. b. On April 27, 2012 a review of Resident 4's clinical record disclosed that the resident was readmitted to the facility on February 28, 2012, with diagnoses including malignant breast cancer and diabetes mellitus. On April 28, 2012 at 2 p.m., an interview with Resident 4, with the licensed vocational nurse as an interpreter, she (the resident) stated that she knows when she needs to use the bathroom and if somebody would help her to go to the bathroom, she the resident can use the bathroom, successfully. The resident further indicated that it is uncomfortable having diaper on. The initial nursing assessment dated February 28, 2012, revealed the resident was continent of bowel and bladder and had good control of bowel and bladder. The Minimum Data Set (MDS) dated April 11, 2012, assessed Resident 4 with short and long term memory problems and required extensive assistance with all activities of daily living and was frequently incontinent of bowel and bladder. On April 28, 2012 at 2 p.m., the Director of	F 278		

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F 278	Continued From page 5 Nursing staff was interviewed regarding the inaccurate assessment of bowel and bladder and no further information provided.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facilities nursing staff failed ensure that each resident's physician orders were carried out, ensure that residents were assessed, and necessary services were provided, to maintain the highest practicable physical well-being for five residents in a sample of 11 (Resident 5, 6, 7, 3, 8). Resident 5, 6, 7, 3, 8, had physician orders that were not carried out. This had the potential to result in ineffective treatment of the resident's health conditions. Findings: 1 a. On 4/28/12 a review Resident 5's clinical record disclosed that Resident 5 was admitted to the facility 1/5/12, with diagnoses that included pneumonia, depressive disorder, and anemia. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 4/18/12, revealed that Resident 5 was alert, could be interviewed and that the resident required extensive assistance in activities of daily	F 309	It is the policy of RGECH that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. • LVN was provided with a one-on-one in-service by the DON on policy and procedure on medication administrations especially on administration of Folic Acid, Dilantin, Benadryl, Potassium and importance of padded side rails and low bed per physician's order. Resident 5, 6, 7, 3, and 8 were reassessed and no adverse reaction observed. • All residents had the potential to be affected by this deficient practice. DON provided in-services to licensed nurses on medication administration and less restrictive devices serves as corrective action for deficient practice.	

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F 309	Continued From page 6 living. On 4/28/12 further review of Resident 5's clinical record revealed a physician's order dated 4/20/12, for the licensed nurses to administer to Resident 5 the following: potassium one tablet, 40 milliequivalents (meq) daily by mouth for two days. A review of the medication record and profile for the month of April 2012, revealed that on 4/20 and 4/21/12, the potassium was not administered. On 4/28/12 further review of Resident 5's clinical record revealed a physician's order dated 4/27/12, for the following: potassium one tablet 40 meq daily by mouth on 4/27 and 4/28/12. A review of the medication record and profile revealed on 4/27/12, the potassium was not administered. On 4/28/12 at 1:04 p.m., a joint review of the clinical record for Resident 5 with the director of nurses (DON) revealed the nurses should have administered the potassium on 4/20, 4/21, and 4/27/12, as indicated in the physician's orders. 1 b. On 4/28/12 a review of Resident 5's clinical record disclosed that Resident 5 was admitted to the facility on 1/5/12, with diagnoses that included pneumonia, depressive disorder, and anemia. A review of the MDS dated 4/18/12, revealed that Resident 5 was not interviewable and was totally dependent in activities of daily living. On 4/28/12 further review of Resident 5's clinical record revealed a physician's order dated 4/18/12, for the resident to receive the following:	F 309	• Pharmacy consultant will conduct medication administration observation every three months. Copies of findings will be provided to the DON for evaluation and corrective actions as needed. The DON will randomly check residents with physician's order of less restrictive devices and ensure they provided to them per MD's order. •All findings of pharmacy consultant will be reported during quarterly Quality Assurance meeting to ensure compliance and for further actions as needed. DON finding will be discussed at the monthly Quality Assurance Meeting for evaluation and oversight. • Compliance date:	6/17/12

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F 309	Continued From page 7 folic acid 1 milligram (mg) by mouth daily as a supplement. A review of the medication record and profile revealed the folic acid was not administered to the resident after 4/21/12. The licensed nurses failed to administer the folic acid table to Resident 5 from 4/22/12 to 4/28/12. On 4/28/12 at 1:04 p.m., a joint review of the clinical record for Resident 5 with the DON revealed the licensed nurse failed to administer the folic acid as ordered by the physician. There was no documentation at the time of review, indicating that the physician's order for folic acid had been discontinued. 2 a. On 4/28/12 a review of Resident 6's clinical record disclosed that Resident 6 was re-admitted to the facility on 4/8/11, with diagnoses that included unspecified essential hypertension, and unspecified psychosis. A review of the MDS dated 3/8/12, revealed that Resident 6 was not interviewable, and required supervision and limited assistance with all activities of daily living except eating. A review of the resident's care plan dated 6/6/11, revealed that the resident was taking an anti-psychotic medication [medication used to treat psychiatric (mental) disorders]. The care plan indicated that a common side effect from the psychiatric medication was postural hypotension. (low blood pressure arising from a change of position). A review of the physicians order dated 4/8/11, indicated for the licensed nurse to monitor	F 309		

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F 309	Continued From page 8 Resident 6 for orthostatic hypotension on the day shift once a week, on Sunday. A review of the medication record and profile revealed that on 4/8/12, there was no documentation to indicate that Resident 6 was assessed for orthostatic hypotension. Further review of the profile revealed that on 4/15 and 4/22/12, there was no documentation that the resident was assessed for orthostatic hypotension by having Resident 6's blood pressure checked in a lying and in a sitting position. On 4/28/12 at 10:12 a.m., during an interview with the DON and a joint review of the medication record and profile confirmed the physician's orders were not followed for Resident 6. There was no additional information presented to the surveyor. 3 a. On 4/28/12 a review of Resident 7's clinical record disclosed that Resident 7 was admitted to the facility on 4/25/12, with diagnoses that included non-psychotic brain syndrome. Further review of the clinical record for Resident 7 revealed the following admission medication order dated 4/25/12: Dilantin (Dilantin is used to treat seizures) 4 milliliters (ml) every eight hours. A review of the medication record and profile for the month of April 2012, revealed Dilantin was administered to Resident 7 to prevent seizures. The medication record also revealed that the licensed nurse did not administer the resident Dilantin on 4/28/12, however. Further review revealed that the administration times were not	F 309		

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F 309	Continued From page 9 legible and the original administration times documented were crossed out. It could not be determined whether the signatures of the licensed nurses were meant for the original times of administration of the Dilantin, which were crossed out, or if the signatures of the licensed nurses were meant for the newly documented times. On 4/28/12 at 9:25 p.m., during an interview with the DON and a joint review of the medication profile, the DON acknowledged that the Dilantin was not administered as indicated in the physician's orders. 3 b. On 4/28/12 a review Resident 7's clinical record disclosed that Resident 7 was admitted to the facility on 4/25/12, with diagnoses that included cellulitis of the leg and foot. On 4/28/12 at 11:15 a.m., the licensed nurse was observed to administer wound care to Resident 7. During the treatment observation the resident was observed to have rashes to her upper back, chest, and scalp. Further review of the clinical record for Resident 7 revealed the following admission medication order dated 4/26/12: Benadryl 25 milligrams via gastric tube twice a day for one week for scattered rash. A review of the medication record and profile revealed the Benadryl was only administered once on 4/27/12, instead of twice. The morning dose was missed. On 4/28/12 at 9:33 a.m., during a joint review of the resident's medication record and profile this	F 309		

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F 309	Continued From page 10 was brought to the attention of the DON who acknowledged the error and presented no additional information to the surveyor. 4. On April 27, 2012 a review of Resident 3's clinical record disclosed that the resident was admitted to the facility on March 23, 2011, with diagnoses including pneumonia, hypertension, senile dementia and pressure ulcer. The Minimum Data Set (MDS) dated February 3, 2012, indicated Resident 3 had short and long term memory problems and required extensive assistance with all activities of daily living. During the initial tour of the facility, on April 26, 2012 at 6:30 p.m., Resident 3 was observed lying on a bed. The right side bed rail had padding. The licensed nurse indicated the padded bed side rail was for protection. The padding did not cover the upper metal bar of the bed side rail. The licensed nurse tried to cover the upper metal bar of the bed side rail, with the padding. On April 27, 2012 at 6 p.m., the bed side rail padding was observed hanging off of the upper bar of the right side bed rail, not covering the metal. On April 28, 2012 at 4 p.m., Resident 3 was observed lying on the bed taking a nap. The right side bed rail padding was observed on the floor, not applied to the bed side rail. At the same time, the nursing supervisor was called. The surveyor showed the nursing supervisor the padding on the floor. Although the nursing supervisor offered to reapply the padding to the bed side rail, the bed side rail pad had broken Velcro, to such an extent that the padding could not be applied securely, to the bed side rail.	F 309		

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F 309	Continued From page 11 On June 17, 2011, there was a physician order for upper padded bilateral half side rails up, as a cushion and to aid in turning and repositioning due to dementia. The facility failed to implement the physician's order for the padded side rails. 5. On April 27, 2012, a review of Resident 8's clinical record disclosed that the resident was readmitted to the facility on April 25, 2012, with diagnoses including hypertension, aphasia and dysphasia. On April 28, 2012 at 11 a.m., Resident 8 was observed lying on a regular height bed. The resident was alert but confused and required total nursing care with all activities of daily living. On April 25, 2012, the physician ordered restraint/postural support/devices, to use a low bed as least restrictive measure. The low bed was not provided to the resident as the physician ordered, until it was brought to the attention of the facility staff on April 28, 2012 at 2 p.m.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	It is the policy of RGECH to prevent urinary tract infection to a resident with an indwelling urinary catheter. • Resident 2 was reassessed of bladder function and no episode of urinary incontinence noted, no urinary catheter was found and the patient was on a toileting plan.	

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	055818	A. BUILDING _____ B. WING _____	04/28/2012

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ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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F 315	Continued From page 12 function as possible. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure residents with indwelling urinary catheters received bladder retraining to restores as much normal bladder function as possible for 2 out of 11 sample residents (Resident 2 and 4). Findings: 1. On April 27, 2012 a review of Resident 2's clinical record disclosed that the resident was readmitted to the facility on March 30, 2012, with diagnoses including pneumonia, hypertension, senile dementia and pressure ulcer. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated April 8, 2012, assessed Resident 2 with short and long term memory problems, required extensive assistance with activities of daily living, and was frequently incontinent of bowel and bladder. During the initial tour on April 28, 2012 at 5:30 p.m., Resident 2 was observed lying on a bed and was talking incoherently in a foreign language. There was a physician's order of March 30, 2012, for bladder retraining program, post 24 hour urine collections for 72 hours, then discontinue the urinary catheter. Clamp urinary catheter every 2 hours for 10 minutes, then release. Discontinue urinary catheter on April 3, 2012. On April 28, 2012 at 2 p.m., the licensed nurse was interviewed about the bladder retraining program. The licensed nurse was unable to provide documented evidence that the bladder	F 315	Resident 4 was reassessed regarding restoring as much bladder and bowel function as possible. Resident was instructed to have a CNA assist her to use the bathroom. CNA and licensed nurse were in-serviced regarding the monitoring of the patient's needs. MDS was in-serviced to monitor accurately the behavior of the patient regarding toilet/bowel and bladder. DON provided in-services to licensed nurses on policy on removal of Foley catheter and bladder retraining. •All residents had the potential to be affected by this deficient practice. DON provided in-services to licensed nurses on bladder retraining serves as corrective action for deficient practice. •DON will check resident prior to removal of foley catheter to ensure bladder retraining is done and documented in the licensed nurse 's notes. The Health Information Director will conduct audits of foley catheter and bladder assessments in monthly basis. All findings will be provided to the DON for corrective actions as needed.	

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F 315	Continued From page 13 retaining program was done. Instead The licensed nurse stated, the urinary catheter was out and the bladder retraining program did not occur. There was no documented evidence of any toileting plan to restore as much normal bladder function as possible. 2. On April 27, 2012, a review of Resident 4's clinical record disclosed that the resident was readmitted to the facility on February 28, 2012, with diagnoses including malignant breast cancer and diabetes mellitus. The MDS dated April 11, 2012, indicated Resident 4 had short and long term memory intact, required extensive assistance with activities of daily living and was frequently incontinent of bowel and bladder. On April 28, 2012 at 2 p.m., an interview with Resident 4, with the licensed vocational nurse as an interpreter, she (the resident) stated that she knows when she needs to use the bathroom and if somebody would help her to go to the bathroom, she the resident can use the bathroom, successfully. The resident further indicated that it is uncomfortable having diaper on. There was no documented evidence of a toileting plan to assist the resident in restoring as much normal bladder and bowel function as is possible.	F 315	•All findings will be discussed at the monthly Quality Assurance Meeting for evaluation and oversight. • Compliance date:	6/17/12
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

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F 318	Continued From page 14 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to provide range of motion treatment and services to increase range of motion and/or to prevent further decrease in range of motion for two of 11 sample residents (Resident 2, and 7). Resident 2 and 7 were admitted to the facility with limited range of motion and did not receive RNA services as ordered by the physician. Findings: On April 27, 2012 a review of Resident 2's clinical record disclosed that the resident was readmitted to the facility on March 30, 2012, with diagnoses including pneumonia, hypertension, senile dementia and pressure ulcer. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated April 8, 2012, indicated Resident 2 had short and long term memory problems and required extensive assistance with activities of daily living. On April 28, 2012 at 11 a.m., after a treatment observation with the licensed vocational nurse and the RNA staff, the evaluator asked the RNA staff when she was to do the range of motion exercises. The RNA staff indicated that he did not do any restorative exercises because there was no physician's order for range of motion exercises. A review of the physician's order dated March 27,	F 318	It is the policy of RGECH that based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. • Resident 2 was immediately assessed by a licensed nurse regarding joint mobility status and there was no change of mobility from 3/27 to 4/27 The physicians were notified that restorative service was not provided as he ordered. No negative outcome. Resident 7 was re-assessed for joint mobility and there has been no change even though no ROM done on April 27 & 28. The physician was notified & he did not give new orders. No negative outcome. • There were 2 licensed nurses who received the orders from the physicians & failed to carry out the orders by not writing it in the RNA forms. Therefore, it was missed by the restorative nursing assistant. Both licensed nurses were counseled and in-serviced regarding; the importance of completing the process of carrying out doctors order. Both licensed nurses voluntarily resigned.	

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F 318	Continued From page 15 2012, indicated there was an order for the RNA to provide active range of motion to bilateral (both) upper and lower extremities and stand/ambulate with a front wheel walker daily, however. On April 28, 2012 at 11:30 a.m., in a further interview with the licensed vocational nurse, she stated that the physician's order was not carried out and no RNA services were provided to the resident since admission to the facility, over three weeks before. The facility failed to provide restorative services to Resident 2, as the physician ordered. b. On 4/26/12 at 7:35 p.m., during the initial tour of the facility, Resident 7 was observed in a reclining position asleep. The gastric (stomach) tube feeding, "Glucerna 1.2", was observed infusing at 30cc per hour into the resident's gastric feeding tube. An oxygen concentrator was observed at the resident's bedside, and the resident was receiving oxygen at a rate of 2 liters per minute via nasal cannula. According to the licensed nurse accompanying the surveyor, Resident 7 was bedridden. On 4/28/12 a review Resident 7's clinical record disclosed that the resident was admitted to the facility on 4/25/12, with diagnoses that included cellulitis of the foot and leg, attention to gastrostomy, and hypertension. The resident was newly admitted to the facility and the MDS had not yet been completed. A review of the physician's order dated 4/25/12, revealed an order for a screening for physical therapy, speech therapy, and occupational therapy. A review of the joint mobility assessment and the	F 318	• Health Information Director will check all new orders daily to assure that doctor's order are transcribed to all the necessary forms, such as physicians order, MAR, RNA form and nurse's notes & care plan. Any missing information will be communicated to the DON for further completion and guidance to licensed nurses. • The DON will randomly monitor to assure that doctor's orders are carried out accurately. Findings will be discussed during the Quality Assurance meeting for compliance and corrective action, if needed. • Compliance date:	6/17/12

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F 318	Continued From page 16 rehabilitation screening by the physical therapist dated 4/26/12, revealed that physical therapy, occupational therapy, and speech therapy services for Resident 7 were not needed at this time. However, the joint mobility assessment for joint mobility limitation indicated that Resident 7 had moderate/severe to severe limitation in the left shoulder and severe limitation in the left and right ankle. On 4/28/12 during a review of the physician's orders for Resident 7, revealed an order dated 4/26/12, indicating the resident was to have an RNA (restorative nursing assistant), to provide gentle passive range of motion to both the upper and lower extremities daily seven times a week. On 4/28/12 at 11:05 p.m., a review of the RNA book revealed no documentation that Resident 7 had been provided gentle passive range of motion to both the upper and lower extremities daily seven times a week by the RNA, as ordered by the physician. There was no documentation in the resident's clinical record that the physician order for range of motion to both the upper and lower extremities had been carried out for two days, on April 27, 2012 and April 28, 2012. During an interview with the Director of Nursing (DON) and a joint review of the clinical record of Resident 7 revealed the physician's order for range of motion to both the upper and lower extremities by the RNA had not been carried out. The DON stated that the physician's order should have been carried out.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 17 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent a resident from falling for one of 11 sample residents (Resident 2). Findings: On April 27, 2012 a review of Resident 2's clinical record disclosed that the resident was readmitted to facility on March 30, 2012, with diagnoses of pneumonia, hypertension, dementia and dysphagia. The initial Minimum Data Set (MDS), a standardized assessment and care planning tool, dated April 8, 2012, revealed the resident had short and long term memory problems, moderately impaired decision-making, and required extensive assistance with all activities of daily living. The fall risk assessment dated March 27, 2012, indicated Resident 2 had a high risk for falls. On April 28, 2012 at 7 p.m., during the initial tour of the facility, Resident 2 was observed lying on a bed, talking incoherently in a foreign language. The resident was shaking her bedrails, and the licensed vocational nurse (LVN) interpreted the resident's shaking the bedrails, stating that the resident was confused. Further review of the clinical record revealed that Resident 2 had a fall incident on April 2, 2012, trying to get out of her bed in the resident's room. The resident's nursing care plan goal of April 2, 2012, was to have no further falls in 30 days. One of the care plan approaches indicated to	F 323	It is the policy of RGECH to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. • Resident 2 was assessed of not able to hold her trunk to sit in a shower chair. CNA was advised to bathe her with 2 assistants to prevent injury. In-service given to CNA to always ask for help in carrying for residents who are unable to sit-up straight. • All residents assessed for ability to sit-up in a shower chair, wheelchair, Geri-chair without bending over and leaning to side to side. No other resident was affected by this deficient practice, this is an isolated case. • In-service was done to all CNA regarding prevention of accident hazard use of devices and sufficient supervision of resident. CNA's were told to prepare necessary equipment before bathing to include shower chair with belt and to ask for assistance while giving baths. The DSD will monitor CNA's during bathing time. The DON will randomly monitor all residents for safety.	

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F 323	Continued From page 18 monitor whereabouts of the resident at least every two hours, increased visual check, encourage to call for assistance during transfer. The licensed nurses notes indicated on April 26, 2012 at 2:15 p.m., Resident 2 had another fall while in the shower chair trying to get out of the chair and hit the left eyebrow on the toilet roll dispenser. The left eyebrow had a bruised spot. The nursing care plan dated April 26, 2012, was not revised as evidenced by the care plan contained the same approaches as were listed for the previous fall of April 2, 2012. There was no evidence that the facility had considered additional interventions to prevent the resident from further falls. On April 28, 2012 at 2 p.m., an interview with the director of nurses (DON) revealed the CNA (Certified Nursing Assistant) who provided care for the Resident, did not provide proper supervision to prevent the resident from falling. However, no specific interventions to address supervision, were identified on the care plan and no specific interventions were identified by the director of nurses to address the supervision needs of the resident to prevent further falls. The facility staff failed to provide adequate supervision to prevent from further falls.	F 323	• All findings will be discussed at the monthly Quality Assurance Meeting for evaluation and oversight. • Compliance date:	6/17/12
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 19 This Requirement is not met as evidenced by: Based on observation, interview, and record review, the dietary staff failed to store and prepare food in a sanitary manner. Findings: On April 26, 2012 from 7:33 p.m. until 7:53 p.m., during the initial tour, the following was observed in the kitchen: 1. A 8 ½ inch (in) deep, round, eight inch in diameter wide, four quart container of rice porridge was left beside the stove top. The evaluator took the temperature of the rice porridge using a probe thermometer, which indicated a temperature of 118 degrees Fahrenheit, well below 140 degrees Fahrenheit, making the rice porridge a potentially hazardous food where there was a high risk for bacterial growth. In addition, there was no cooling temperature log sheet indicating how long the rice porridge had been cooling without refrigeration, or what the rice porridge's initial temperature was after the porridge had finished cooking. During an interview with the dietary supervisor, she stated the porridge was primarily a food substitute for the Asian residents in the facility. A review of the facility policy on preparing cultural Asian foods such as porridge and chicken adobo, indicates that the food will be allowed to cool down to room temperature approximately 72-80 degrees, then stored in the refrigerator till the next day. The procedure did not indicate how long the food should be left out while cooling down nor how hot the food should be when finished cooking.	F 371	It is the policy of RGECH to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare distribute and service food under sanitary conditions. • 1. The rice porridge was discarded and an in-service was immediately done to all dietary staff regarding the procedure of cooling down food prior to putting it in the refrigerator. The facility's policy was revised and discussed to prevent reoccurrence. 2. The purse was removed from the food preparation table and stored in the employee closet. 3. The towel dispenser was refilled over the food preparation sink. 4. The exit door leading to a room containing a floor freezer with vegetables and the dumb waiter on the other side of the kitchen storage area was closed to prevent vermin from entering the building. 5. The section where the bottled water is stored was cleaned and rearranged, including the removal of unnecessary items.	

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F 371	Continued From page 20 During an interview with the administrator, he could not recall if the facility dietary consultant had reviewed this policy before the facility adopted it. A review of the resident census completed by the facility on April 26, 2012, indicated 28 of 41 residents in the facility were Asian. A review of the roster matrix form completed by the facility on April 27, 2012, indicated only one resident was on an enteral feeding pump. 2. A purse was left on the food preparation table. 3. No towels were in the towel dispenser over the food prep sink. 4. The exit door leading to a room containing a floor freezer with vegetables and the dumb waiter on the other side of the kitchen storage area was left open, creating potential for vermin to enter the building. 5. Another section of the kitchen was observed with bottled water stored in a laundry sink filled with aprons and personal sundry items such as hand lotion and mouth rinse. A section near the laundry sink was also observed to be disorderly with clothes, prepackaged biscuits, and detergent bottle supplies piled in a corner on a table. During an interview, the dietary supervisor stated the bottled water and the other items were not for the residents but were rather for use by the staff.	F 371	• A thorough tour of the kitchen by the Dietary Supervisor, Administrator & Maintenance was conducted. The kitchen was clean and found no food item being cooled down at the time of the tour. The Dietary Supervisor will monitor daily that the kitchen be clean and orderly and no food will be cooled down without monitoring. No other deficient practice was observed. • In-serviced all the dietary staff regarding cleanliness and cooling down of food. The Dietary staff was told to keep all personal items, including purses in the closet designated for employees. The towel dispenser will be monitored and kept filled. The exit door leading to the room containing a floor freezer with vegetables and dumb waiter will be closed at all times. • A log book containing the things to be checked daily, weekly and monthly will be used to document the monitoring system. Administrator to check the log and will assure compliance. The Findings will be discussed during the Quality Assurance meeting for compliance and corrective action, if needed. • Compliance date:	6/17/12
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at	F 458		

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F 458	Continued From page 21 least 100 square feet in single resident rooms. This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 12 out of 17 resident bedrooms measured at least 80 square feet per resident. Findings: A review of a facility room waiver request letter dated April 26, 2012, indicated the following rooms did not meet the 80 square feet(sq. ft) per resident requirement in multiple bedrooms: Room Beds sq. ft. sq. ft. / resident 101 2 145 72.5 102 3 236 78 104 4 309 77 106 4 299 74.5 109 4 303 76 110 2 150 75 111 2 150 75 112 2 150 75 114 2 150 77 115 2 150 75 116 2 145 72.5 117 2 145 72.5 During the course of the survey on April 26, 27, and 28, 2012, all of the residents in the rooms listed above were observed to be fully ambulatory or able to propel themselves in wheelchairs while displaying no difficulties in getting in and out of their rooms. The evaluator did not observe any problems with residents while the facility staff were providing care to the residents in the 25 residents' rooms.	F 458	• The facility submitted a room variance to the surveyor on 4/26/12 for rooms 101, 102, 104, 106, 109, 110, 111, 112, 114, 115, 116, and 117. All rooms had plenty of space for residents to move around freely in the rooms and for resident care equipment. All the rooms had adequate privacy curtain for each resident and direct access to the corridor. Please see attached waiver. • The facility will continue to ensure the residents in the variance rooms to have plenty of space to move around freely and have sufficient space for resident care equipment. • The Administrator and Maintenance Supervisor will make daily rounds to ensure all rooms are kept uncluttered and there is enough space for residents to be transferred in and out of the room. The DSD will in service all nursing personnel on accommodation of needs in regards to the resident's safety, health and security. The Director of Nurses will make rounds to ensure that there is adequate space for nurses to provide care. Bi-annual follow-up in services will be conducted to ensure continued compliance of the facility.	

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FORM APPROVED
OMB NO. 0938-0391

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
	055818	A. BUILDING _____ B. WING _____	04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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F 458	Continued From page 22 During the group resident meeting on February 24, 2012 and during individual interviews, no residents complained about their rooms being too small for them or having problems related to room space. A review of the facility's room waiver request indicated that the health and safety of the residents were not adversely affected in any way.	F 458	• The Administrator and Department Heads will make daily rounds to monitor compliance. During the QA meeting, the findings will be discussed to ensure compliance. • Compliance date:	6/17/12
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain clinical records in accordance with accepted professional standards and practice that are accurately documented for 1 of 11 residents (Resident 2). In addition, the facility failed to accurately document the time medication were administered to 5 of 5 residents observed during the medication pass. Findings: On April 27, 2012 a review of Resident 2's clinical	F 514	It is the policy of RGECH to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible, and systematically organized. • A. Resident 2 pressure ulcer was re-assessed as to the site of the wound, the skin care and pressure ulcer record indicates that the pressure ulcer was on the right lateral malleolus area. The LVN and the DON were counseled and in-serviced regarding the correct site of the pressure ulcer. B. Residents A,B,C,D,E, attending physicians were notified on 4/27/12 that their medication was received late. An interview with an alert resident indicated that they received their medication on time as written in the MAR. No other resident was affected by the deficient practice.	

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F 514	Continued From page 23 record disclosed that the resident was readmitted to the facility on March 30, 2012, with diagnoses of pneumonia, hypertension, dementia and pressure ulcer. On March 30, 2012 the resident was assessed with a Stage V pressure ulcer on the right malleolus area. The physician order dated March 30, 2012, noted to cleanse the pressure ulcer to left lateral malleolus with normal saline, pat dry, apply santyl and cover with dry dressing then wrap with kerlix daily. On April 28, 2012 at 11 a.m., during a treatment observation, the pressure ulcer was observed on the right lateral malleolus area. The licensed vocation nurse was interviewed and the surveyor asked if there was a pressure ulcer on the right malleolus area. The LVN responded, that the pressure ulcer was on the left malleolus area. On the same day at 11:30 a.m., the LVN and the DON indicated there was a typographical error in transcribing, the location of the pressure ulcer. b. On 4/27/13 the licensed nurse was observed to conduct the medication pass. The licensed nurse was observed to pass 5 p.m. medications to the following residents: At 7:05 p.m. Resident A was observed to receive the following medications. Exelon 3 milligrams (mg) 1 capsule by mouth (M.D. order dated 2/17/12, for dementia) Coumadin 3.5 mg by mouth (M.D. order dated 2/27/12 for atrial fibrillation) Hydralazine 25 mg one tablet by mouth (M.D. order dated 8/13/11 for Hypertension)	F 514	• After counseling and in-service with the licensed nurse who was late in giving medication, he voluntarily resigned. A review of the MAR and med-pass observation by the DON, showed all medication being given on time and documented timely. • In-serviced licensed nurses regarding correct response by verifying the medical record to ensure accuracy. In-service all licensed nurses as to documentation of the exact time when the medication was administered and any deviation from the prescribed hours will be communicated to the doctor. Licensed nurse will notify the DON and the Health Information Director will monitor documentations weekly and will report to the DON. • All findings will be discussed at the monthly Quality Assurance Meeting for evaluation and oversight. • Compliance date:	6/17/12

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F 514	Continued From page 24 At 7:43 p.m. Resident B was observed to receive the following medications: docusate sodium 100 mg by mouth (M.D. order dated 6/16/11, stool softener) Magnesium oxide 400 mg one tablet by mouth (M.D. order dated 6/16/11, supplement) Metoprolol one tablet 25 mg by mouth (M.D. order dated 6/16/11 for hypertension) Os-cal 500 mg one tablet by mouth (M.D. order dated 7/7/11, supplement) Accolate 20 mg 1 tablet by mouth (M.D. order dated 7/19/11 for COPD) Effexor one tablet 37.5 mg by mouth (M.D. order dated 6/20/11 for anxiety) At 8:00 p.m. Resident C was observed to receive the following medications: Colace 100 mg capsule by mouth (M.D. order dated 4/19/12 for constipation) Isordil 10 mg by mouth (M.D. order dated 4/19/12 for hypertension) Megace 10 milliliters (ml) by mouth (M.D. order dated 4/19/12, appetite stimulate) Sinemet 25 mg one tablet by mouth (M.D. order dated 4/19/12 for Parkinson's disease) Symmetrel 100 mg by mouth (M.D. order dated 4/19/12 for Parkinson's Disease) At 8:07 p.m., Resident D was observed to receive the following medications: Amaryl 1 mg tablet by mouth (M.D. order dated 4/5/12 for diabetes) Metformin 500 mg by mouth (M.D. order dated 4/5/12 for diabetes) Pletal 100 mg by mouth (M.D. order dated 2/16/12 for coronary artery disease) At 8:20 p.m. Resident E received the following medications: Os-cal 500 mg one tablet by mouth (M.D. order	F 514		

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F 514	Continued From page 25 dated 2/23/11, supplement) Namenda 10 mg one tablet by mouth (M.D. order dated 2/23/11 for dementia) Colace 20 ml (M.D. order dated 2/23/11 for constipation) On 4/27/12 at 8:30 p.m., during an interview with the licensed nurse he stated that he was the only medication nurse passing medications for residents, and that he passes medications until late at night. The licensed nurse stated that he still had four more patients who required administration of their 5 p.m. medications. During an observation of the medication administration records for Residents A,B,C,D,E, the licensed nurse was observed to document that he administered the medications at 5 p.m. instead of the actual time of the administration. The medication administration record did not accurately reflect the actual times that the residents were administered the medication.	F 514		

Plan of Correction received and approved by 07598

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA950000104	A. BUILDING _____ B. WING _____ 6-14-12	04/28/2012

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ROYAL GARDEN EXTENDED CARE HOS	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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A 000	Initial Comments The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: 07598 09697 10115 Total resident Sample: 11 Total resident Population: 41	A 000	This plan of correction constitutes our written credible allegation of compliance for the deficiencies noted. This facility will be in substantial compliance no later than 6/17/12. It is the policy of RGECH that medication shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.	
A 168	T22 DIV5 CH3 ART3-72313(a)(6) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows: (6) Medications shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. This Statute is not met as evidenced by: Based on observation , interview and record review, the facility failed to accurately document the time medication were administered to 5 of 5 residents observed during the medication pass. Findings: On 4/27/13 the licensed nurse was observed to conduct the medication pass. The licensed nurse was observed to pass 5 p.m. medications to the following residents:	A 168	• Resident A was assessed for adverse reaction of the late medication that was given. Resident A received Coumadin for atrial fibrillation and pulse rate is within normal range. Resident also taking Hydralazine for hypertension, blood pressure was observed to be within normal range. Resident B received Metoprolol for hypertension, Accolate & Effexor, the blood pressure is within normal range. No signs or symptoms of shortness of breath noted, breathing is good, no chest pain noted. No episode of anxiety, resident's behavior is stable. No adverse reaction.	

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A 188	Continued From page 1 At 7:05 p.m. Patient A was observed to receive the following medications. Exelon 3 milligrams (mg) 1 capsule by mouth (M.D. order dated 2/17/12, for dementia) Coumadin 3.5 mg by mouth (M.D. order dated 2/27/12 for atrial fibrillation) Hydralazine 25 mg one tablet by mouth (M.D. order dated 9/13/11 for Hypertension) At 7:43 p.m. Patient B was observed to receive the following medications: docusate sodium 100 mg by mouth (M.D. order dated 6/16/11, stool softener) Magnesium oxide 400 mg one tablet by mouth (M.D. order dated 6/16/11, supplement) Metoprolol one tablet 25 mg by mouth (M.D. order dated 6/16/11 for hypertension) Os-cal 500 mg one tablet by mouth (M.D. order dated 7/7/11, supplement) Accolate 20 mg 1 tablet by mouth (M.D. order dated 7/19/11 for COPD) Effexor one tablet 37.5 mg by mouth (M.D. order dated 6/20/11 for anxiety) At 8:00 p.m. Patient C was observed to receive the following medications: Colace 100 mg capsule by mouth (M.D. order dated 4/19/12 for constipation) Isordil 10 mg by mouth (M.D. order dated 4/19/12 for hypertension) Megace 10 milliliters (ml) by mouth (M.D. order dated 4/19/12, appetite stimulate) Sinemet 25 mg one tablet by mouth (M.D. order dated 4/19/12 for Parkinson's disease) Symmetrel 100 mg by mouth (M.D. order dated 4/19/12 for Parkinson's Disease) At 807 p.m., Patient D was observed to receive the following medications:	A 188	Resident C received Isordid for hypertension, Symmetrel for Parkinson's disease. No adverse reaction observed. Blood pressure is within normal range & no change in tremor even though medication was given late. Resident D received Amaryl for diabetes, Metformin for diabetes, both were given late. Resident exhibited no sign of hyperglycemia or hypogylcemia. Resident E received Oscal, namenda & colace given late. There was no adverse reaction. The physicians of the residents listed above were notified of the deficient practice and advised licensed nurses to continue to monitor the residents. Licensed nurse involved in the late administration of medication was verbally counseled regarding the passing of medication with emphasis on giving the medication at the right time and documenting the exact time it was given. He also attended a mandatory in-service on med pass on 4/30/12. Employee voluntarily resigned.	

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A 188	Continued From page 2 Amaryl 1 mg tablet by mouth (M.D. order dated 4/5/12 for diabetes) Metformin 500 mg by mouth (M.D. order dated 4/5/12 for diabetes) Pletal 100 mg by mouth (M.D. order dated 2/16/12 for coronary artery disease) At 8:20 p.m. Patient E received the following medications: Os-cal 500 mg one tablet by mouth (M.D. order dated 2/23/11, supplement) Namenda 10 mg one tablet by mouth (M.D. order dated 2/23/11 for dementia) Colace 20 ml (M.D. order dated 2/23/11 for constipation) On 4/27/12 at 8:30 p.m., during an interview with the licensed nurse he stated that he was the only medication nurse passing medications for residents, and that he passes medications until late at night. The licensed nurse stated that he still had four more patients who required administration of their 5 p.m. medications. During an observation of the medication administration records for Residents A,B,C,D,E, the licensed nurse was observed to document that he administered the medications at 5 p.m. instead of the actual time of the administration. The medication administration record did not accurately reflect the actual times that the residents were administered the medication.	A 188	• DON will randomly observe medication pass to assure that medication was given within 2 hours after dose was prepared. Documentation will also be checked, that initials are done right after medication are given. • An in-service to all license nurses was done on 4/30/12 on med pass. A second license nurse was hired to lessen the load of the medication nurse & also to allow compliance in implementing doctor's orders regarding med pass time. The pharmacy consultant will observe med pass every other month to assure that med pass procedure is followed as written in the doctor's order & facility policy. The Health Information Director will audit MAR on a monthly basis. • DON will monitor that med pass is done accurately and will be responsible that every licensed nurse will administer medication as prescribed. The result of the monitoring will be discussed in the Quality Assurance meeting for recommendations if needed. • Compliance date:	6/17/12