STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056133	A. BUILDING _____ B. WING _____	07/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST HILLS HEALTH & REHAB CENTER	7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304

(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 Licensing and Recertification Survey. Representing the Department of Public Health: [redacted] RN-HFEN [redacted] RN-HFEN [redacted] REHS, HFE Total Population: 132 Sample Size: 24 Highest S/S= F	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care	F 164		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mmaghamian RN | TITLE: RN | (X6) DATE: 8/7/2012

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

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F 164	Continued From page 1 institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the licensed nursing staff member observed resident's personal privacy by fully drawing the privacy curtain while observing the resident's indwelling catheter for one out of 24 sample residents (14). Findings: According to the admission record, Resident 14 was originally admitted to the facility on April 25, 2008 and readmitted on June 16, 2012, with diagnoses that included acute renal failure, diabetes mellitus, atony of bladder, and hemodialysis. The Minimum Data Set (MDS) assessment dated June 23, 2012, indicated the resident was [redacted] totally dependent on staff for activities of daily living, and has indwelling catheter for bladder control due to urinary retention. On July 9, 2012, at 8:35 a.m., during the initial tour of the facility, the Registered Nurse 1 (RN 1)	F 164	F 164 The licensed staff immediately provided privacy to resident 14 by pulling the privacy curtain. The DNS made rounds and found that all resident's personal privacy was respected. The DNS and DSD will periodically perform rounds throughout the facility to ensure that privacy rights are respected. The DSD performed an in-service to staff about residents' privacy rights. The Administrator will perform random rounds on each shift to make sure that residents' privacy rights are respected. Administrator will report trends and findings to the QA Committee as needed.	7-9-12 7-27-12

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F 164	Continued From page 2 was asked to assist with observing the resident's indwelling catheter site while the resident was lying in his bed in the room. RN 1 did not pull the resident's privacy curtain to prevent exposure of the resident to others. There was one other resident sharing the room and the resident was in view of his roommate. On July 9, 2012, at 8: 50 a.m. during an interview with RN 1, she stated that she should have closed the privacy curtain to ensure the resident's privacy. A review of the facility's policy on Privacy (not dated), indicated in order to preserve personal privacy, staff shall keep privacy curtains pulled closed when administering personal procedures (shutting resident's door is insufficient).	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide proper grooming to a male resident by not removing facial hair for one out of 24 sample residents (13). Findings: On July 9, 2012, at 8: 55 a.m. during the initial tour of the facility with Registered Nurse 1 (RN 1),	F 241	F241 The CNA immediately shaved the resident. The DSD made rounds and found that no other residents were in need of grooming assistance. The DSD will in-service staff about the grooming policies and practices. The DNS will make periodic rounds to make sure all residents are groomed properly. She will report all findings to the DSD.	7-09-12 7-09-12 7-27-12

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F 241	Continued From page 3 Resident 13 was observed in bed with facial hair. This was brought to the attention of RN 1. On July 9, 2012, at 9 a.m., during an interview with the resident, he stated he would like to have his facial hair removed. At 3:45 p.m., during another interview with the resident, he was smiling and stated that the staff had just shaved him and he liked it. According to the admission record, Resident 13 was admitted to the facility on February 18, 2010, with diagnoses that included multiple sclerosis, amnesia, [redacted] and [redacted]. The Minimum Data Set (MDS) assessment dated April 19, 2012, indicated the resident was [redacted] and required total assistance in activities of daily living. The facility had no policy for shaving but the Certified Nursing Assistant's (CNA) undated job description indicated assist resident with dressing and grooming including shaving and hair care.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to provide an appropriate seat height for a resident at the dining room table in order to reach her food and to maintain her independence while eating for one Randomly Selected Resident (RSR 25). Findings: A review of the Face Sheet indicated RSR 25, a 100 year old female, was admitted to the facility on January 29, 2007, with diagnoses which included [redacted] and osteoporosis. A review of the Minimum Data Set (MDS - a standardized comprehensive assessment of the resident's problems and conditions), dated January 5, 2012, indicated the resident had long-term memory problems, [redacted] and needed limited assistance from staff for set up of meals and eating. A review of the Physician Order, dated January 2, 2010, indicated two chicken legs for lunch and on February 14, 2012, the diet order indicated mechanical soft diet, finely chopped with no added salt. On July 9, 2012, at 12:20 p.m., during the dining observation, RSR 25 was observed hunched over in her wheelchair which was placed in front of a round table while she was trying to eat her lunch. The round table was directly at her nose level. The resident was trying to reach her food by trying to extend the end of her fork all the way	F 246	F246 Facility provided resident 25 with a low over bed table to use in the front dining room. Resident was satisfied with this accommodation and was positioned correctly. The Occupational Therapist performed rounds while residents were dining and found no other residents who needed accommodations to eat. The Occupational Therapist, DSD and DNS will periodically perform rounds while residents are dining to ensure proper positioning and that dining needs are accommodated. The DNS will report findings to Administrator.	7-09-12 7-12-12

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F 246	Continued From page 5 and every time the resident wanted to take a sip of her coffee she had to push her wheelchair back in order to create space to tilt the coffee cup. On July 9, 2012, at 12:40 p.m., in an interview with the Registered Nurse (RN) 2, said the resident was not positioned correctly because the table was at her chin level. A review of the facility's policy and procedures titled Positioning Residents During Meal Times indicated the objective of the policy is to ensure proper positioning during meals to accommodate residents' needs by assessing the resident before meal times, ensuring that resident is in the correct seating position prior to serving the meal, and by ensuring the table being used for the resident is at appropriate height.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident's pain was continuously assessed, monitored, promptly and effectively managed as long as the pain persisted to prevent suffering	F 309		

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F 309	Continued From page 6 from pain and failed to immediately notify the physician and obtain treatment instructions when the scheduled pain medications were not effective to achieve sustained relief until the next scheduled pain medication administration time for one in a sample of 24 residents (6). Findings: According to the admission information, Resident 6 was admitted to the facility on December 12, 2011, with diagnoses that included chronic pain, debility, cachexia, [redacted] gastroesophageal reflux disease, diverticulitis colon without hemorrhage, hypertension, osteoporosis [redacted], and hospice care. The physician's orders dated December 12, 2011, indicated the resident was to receive Fentanyl patch 12 mcg/hr every 72 hours for pain, Lidoderm 5% patch to be applied to the affected area, on at 9 a.m., off at 9 p.m., Neurontin 300 milligrams (mg) orally, twice a day for pain and Tylenol 325 mg 2 tablets (650 mg) every 4 hours as needed for mild pain. The Pain Assessment/ Management form dated December 12, 2011, indicated the resident had generalized body pain. The form did not indicate the present level of pain as indicated. The plan recommendation was to monitor the pain as indicated, administer pain medication as ordered, notify the physician for any changes in condition as indicated, and monitor the effectiveness of pain medication and document as indicated. The Pain Risk Assessment form upon admission dated December 12, 2011, March 21, 2012 and	F 309	F309 Facility received a new order to increase the pain medication for resident 6. The resident was seen by her attending physician and care needs were identified. After the pain medications were changed, the resident was reassessed for pain and the resident's pain was 2-3 out of 10, which is her tolerable level of pain. The DNS checked other residents receiving pain medications and found that their pain management was appropriate. DNS will periodically audit pain assessments to ensure that resident's pain is managed appropriately. The Pharmacy Consultant will review residents on pain medications monthly and report findings to DNS and Administrator.	7-11-12 7-11-12

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F 309	Continued From page 7 June 14, 2012, indicated the resident was at a high risk for pain. The Minimum Data Set (MDS- a standardized comprehensive assessment of the resident's problems and conditions) dated December 25, 2011, indicated the resident was modified in her [redacted], had clear speech, was understood and understand others. The physician's order dated April 23, 2012, indicated the Fentanyl patch was increased to 50 mcg. The order dated May 23, 2012, indicated the Fentanyl patch was increased to 75 mcg every 72 hours for pain management. The order dated June 20, 2012, indicated the medication was increased to 87 mcg every 72 hours for pain management. According to the Pain Assessment Flowsheets for May 5 - 31, 2012, June 7- 29, 2012, and July 1 - 9, 2012, the resident was in pain almost daily. The pain was not totally relieved after the administration of the pain medication. The care plan dated June 14, 2012, indicated the resident had [redacted] related to pain and discomfort. One of the approaches was to notify the physician for any increase in pain/discomfort during mobilization attempt not relieved by the current pain medications. On July 9, 2012, at 9:55 a.m., during the tour of the facility the resident was complaining of pain to the Evaluator. During an interview on July 9, 2012, at 12:40	F 309		

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F 309	Continued From page 8 p.m., the resident told the evaluator she was in pain every day all day. She went on to say the pain medication did not help. On July 10, 2012, at 7:45 a.m., the resident told the evaluator she was in chronic pain all night long. On July 11, 2012, at 10:45 a.m. the evaluator went into the resident's room and noticed a strong urine and body odor emanating from the resident. Her teeth were also coated with a yellowish substance. The evaluator asked the resident if she had a shower recently. She replied, "no". She went on to say she had a bed bath yesterday. The resident said she does not like to take showers because the seat on the shower chair was too hard and made her whole body hurt. The resident said, "it is time for me to go to heaven because I am in so much pain." During an interview on July 11, 2012, at 10:50 a.m., Certified Nursing Assistant (CNA) 2 said the resident complained of pain everyday all day. She also said the resident refused showers. The evaluator asked CNA 2 if she knew why the resident refused showers, she said, "no". During an interview on July 11, 2012, at 11:10 a.m., Licensed Vocational Nurse (LVN) 1 said he was going to call the hospice nurse and get an order for a better pain medication. The evaluator asked why they were not calling the physician, he said they call the hospice nurse. However, the care plan indicated the physician was to be notified.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 9 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 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's urinary indwelling catheter was secured to prevent the potential for trauma to the urethra due to accidental dislodgement of the catheter (14), failed to ensure the free flow of urine by positioning the urinary drainage bag below the level of the bladder (12), failed to provide bowel and bladder (B/B) retraining program to improve urinary incontinence and restore as much normal bladder function as possible (3, 11), for four out of 24 sample residents (3, 11, 12, 14). Findings: a. According to the admission record, Resident 11 was initially admitted on March 5, 2010 and was readmitted on October 7, 2011, with diagnoses that included fracture of neck of femur, osteoporosis, [redacted], and difficulty walking. The Minimum Data Set (MDS) assessment dated	F 315	F315 The catheter strap was immediately secured for resident 14. Facility reassessed 4 residents for bowel and bladder retraining and a training program was restarted. DNS gave an in-service for licensed staff on 7-18-12 and CNAs on 7-27-12. All catheter bags were checked for correct placement and storage. DNS and MDS Nurse reviewed the last month's resident bowel and bladder assessments and no declines were noted. Licensed staff was in-serviced on proper identification of residents with a decline in bladder function and initiating interventions to attempt to restore as much bowel and bladder function as possible. DNS will perform periodic chart reviews to ensure that bowel and bladder retraining programs are provided to residents with a decline in function. DNS will report trends and statistics to Administrator as needed.	7-10-12 7-18-12 7-27-12 7-10-12

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F 315	Continued From page 10	F 315		

April 23, 2012, indicated the resident could make self understood and understand others, was always incontinent of bowel and bladder, and required extensive assistance from staff for all activities of daily living except eating and locomotion.

The Bladder Incontinence Assessment dated October 7, 2011 to April 23, 2012, indicated a total score of 17 & 16 respectively, if the resident had multiple daily episodes (little or no control) for bladder continence.

The resident had a physician's order dated June 29, 2012, at 3: 30 p.m., for bowel and bladder retraining for 14 days.

There was a plan of care for B/B retraining program for 14 days dated June 29, 2012. The approaches included to monitor level of awareness to establish potential for a formalized bladder and bowel retraining program and to offer use of bed pan or toilet in the morning, after each meals or before bed time.

A review of the B/B Retraining Program form dated June 29 - July 12, 2012, indicated the resident was not provided toileting program as ordered by the physician.

The License Nurse Record dated July 7, 2012, indicated the resident was checked for bladder retraining program and assisted with toileting PRN (as needed) checked every two hours. There was no documentation that the licensed nurses were assessing the resident's progress in the B/B retraining program.

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F 315	Continued From page 11 On July 9, 2012 at 11 a.m., and July 10, 2012 at 10 a.m., during observations the resident was wearing incontinent brief. On July 10, 2012, at 11: 35 am., during an interview, Registered Nurse 1 (RN 1) stated the resident upon admission was assessed and determined to be incontinent, and sometimes continent. She was placed by the physician on a 14 days bowel and bladder training program. However, the staff did not follow it up, monitor and documented properly in the accurate forms. The facility's policy and procedure titled "Bladder & Bowel Retraining Program," undated, indicated bowel and bladder patterns will be monitored for time of day, amount, and frequency of occurrence. Observe and record voiding pattern to establish a definite schedule. Ideally toilet every two hours around the clock for five to seven days. Weekly progress notes will be performed by a licensed nurse. As a guideline, program will last for two weeks, but each resident will be assessed weekly for progress. However, these were not done. b. According to the admission record, Resident 12 was initially admitted to the facility on November 9, 2011 and was readmitted on March 30, 2012, with diagnoses that included diabetes mellitus, prostate cancer, Atrial Fibrillation and gastrostomy tube (GT) placement. The Minimum Data Set (MDS) assessment dated May 7, 2012, indicated the resident was [redacted], was totally dependent on staff for physical mobility and activities of daily living and had an indwelling urinary catheter.	F 315		

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F 315	Continued From page 12 The resident had a physician's order dated March 31, 2012, for an indwelling catheter for urinary retention. A plan of care dated April 12, 2012, addressed the problem of urinary retention and the intervention was to maintain proper alignment of Foley catheter to promote proper drainage and the catheter drainage bag should be below the level of the bladder. On July 9, 2012, at 9:05 a.m. during the initial tour of the facility, the resident was observed with an indwelling urinary catheter connected to a drainage bag. The catheter drainage bag was lying on the bed with the resident. The indwelling catheter was not place below Resident's 12 bladder to promote proper drainage. c. According to the admission record, Resident 14 was originally admitted to the facility on April 25, 2008, and readmitted on June 16, 2012, with diagnoses that included acute renal failure, diabetes mellitus, atony of bladder and hemodialysis. The Minimum Data Set (MDS) dated June 23, 2012, indicated the resident was [redacted] totally dependent on staff for activities of daily living and has indwelling catheter for bladder control due to urinary retention. The resident had a physician's order dated June 16, 2012, for an indwelling catheter, for neurogenic bladder.	F 315		

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F 315	Continued From page 13 A plan of care dated June 16, 2012, addressed the problem of alteration in urinary elimination secondary to use of Foley Catheter. One of the interventions was to maintain proper alignment of Foley catheter to promote proper drainage. On July 9, 2012, at 9:05 a.m., during an initial tour of the facility, the resident was observed with an indwelling urinary catheter connected to a drainage bag. The resident's indwelling catheter was not secured to the resident's thigh and/or strapped to prevent pain from pulling and accidental dislodgement that could cause trauma to the urethra. During an interview with the Director of Nursing (DON) on July 9, 2012, at 10:10 a.m. she stated that the catheter should be secured to the thigh when indicated and ensure that the catheter bag is hanging freely. The facility's undated Policy and Procedure, titled "Urinary Catheter Care," indicated secure the Foley catheter to the thigh. Unsecured catheter can lead to bleeding, trauma, bladder spasm from pressure and traction. Securement devices stabilize that catheter and prevent tension and drag, thus reducing friction and trauma within the urethra and the bladder. It is recommended that catheter be secured to the thigh for women and to the upper thigh or lower abdomen for men. The lower abdominal or upper thigh position in men gently curves the penis up and to the side and decreases the potential for pressure necrosis and urethral erosion at the penile-scrotal junction. (Swearing, Pamela DL. Current concept in catheter management, Pages	F 315		

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F 315	Continued From page 14 446-449).).	F 315		

d. A review of Resident 3's Face Sheet indicated the resident, a 73 year old male, was admitted to the facility on March 28, 2012, with diagnoses which included pressure ulcer Stage III, Foley catheter (a thin sterile tube inserted into the bladder to drain urine into a bag), muscle weakness, and resolving pneumonia.

A review of the Minimum Data Set (MDS - a standardized comprehensive assessment of the resident's problems and conditions) dated April 22, 2012, indicated the resident was alert and oriented, required extensive assistance from staff for transferring and toilet use, had a Foley catheter and was not on any toileting program.

A review of the Physician's Orders dated June 5, 2012, indicated to discontinue (June 6, 2012) the Foley catheter per facilities protocol by clamping the catheter for 2 hours, release for 15 minutes for a total of 24 hours and then discontinue the catheter. The orders also indicated to start bowel and bladder re-training for the next 2 weeks.

The Care Plan for Bladder and Bowel Retraining dated June 6, 2012, indicated the resident has urinary and bowel elimination, alteration in patterns as manifested by actual incontinence of urine and bowel and that resident was on a bladder and bowel retraining program for the next two weeks. The approaches were to monitor level of awareness to established potential for a formalized bladder and bowel retraining program

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F 315	Continued From page 15 and to offer use of bed pan or toilet in the morning, after each meals or before bedtime. The Physician's Order dated June 11, 2012, indicated the resident was started on Cipro (antibiotic), 500 milligram (mg), twice a day for urinary tract infection. On June 12, 2012, the orders indicated to re-insert the Foley catheter due to urinary retention (the lack of ability to urinate), and to use Cardura (is used in men to treat the symptoms of an enlarged prostate which include difficulty urinating) 2 mg twice a day. On June 15, 2012, there was a physician's order to do bladder training and to discontinue the Foley catheter again. On June 18, 2012, the orders were clarified to discontinue Foley catheter per facilities protocol (June 19, 2012), start on June 18, 2012 at 8 a.m., clamp Foley catheter for 2 hours, release for 15 minutes for a total of 24 hours and then discontinue the catheter. The Bowel and Bladder Retraining Program form dated June 6 - 19, 2012, indicated the resident had some episodes of bladder continence mixed with incontinence. There was no weekly progress report of the resident's performance in regaining bladder control. The Bowel and Bladder Assessment form dated June 19, 2012, indicated the resident score was 15 (a score of 15 or above indicated the resident is not a candidate for toileting program nor bowel and bladder training). On July 9, 2012 at 8:35 a.m., in an interview with Resident 3, he said he is currently somewhat incontinent of urine and wears an incontinent brief because he can not stand up to use the toilet. The resident said he would like to be able to	F 315		

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F 315	Continued From page 16 control his urine. On July 9, 2012 at 3:15 p.m., in an interview with the Minimum Data Set (MDS) Coordinator, he said the resident had been on a bowel and bladder re-training program, however, the facility's licensed nurse did not assess the progress of the bowel and bladder retraining program. A review of the facility's policy and procedures titled Bladder and Bowel Retraining Program, indicated the purpose of the bowel and bladder retraining program is to assist the resident in gaining control of bowel and bladder function and a weekly progress notes and an assessment will be performed by a licensed nurse for progress.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used [redacted] are not [redacted] ese drugs unless [redacted] is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use [redacted] receive gradual dose reductions, and	F 329		

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F 329	Continued From page 17 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a gradual dose reduction was attempted for a resident on [redacted] 1 milligram (mg) for [redacted] manifested by recurrent restlessness) and was monitored for the rationale it was written for. Findings: According to the admission information, Resident 6 was admitted to the facility on December 12, 2011, with diagnoses that included chronic pain, debility, cachexia, [redacted] gastroesophageal reflux disease, diverticulitis colon without hemorrhage, hypertension, osteoporosis, and [redacted]. The physician's order dated December 12, 2011, indicated the resident was to receive Ativan 1 mg at bedtime routinely for [redacted] manifested by recurrent restlessness leading to shortness of breath. The order also indicated the resident was to receive [redacted] 1 mg every 4 hours as needed for anxiety, manifested by recurrent outbursts of anger. The staff was to monitor the episodes of outbursts of anger and recurrent restlessness leading to shortness of breath.	F 329	F329 Facility asked the resident's primary care physician to revisit the resident and make changes if necessary. The PCP decreased the PRN dose for Ativan. DNS checked other residents receiving psychotherapeutic drugs to see if a dose reduction can be made. The facility holds a behavioral management meeting twice monthly to identify residents on psychotherapeutic drugs and make reductions as indicated. The DNS will report findings monthly at the QA Committee meeting.	7-12-12 7-12-12

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F 329	Continued From page 18 The Consultation Report completed by the pharmacist dated June 12, 2012, indicated the resident had been on [redacted] 1 mg at bedtime since December 19, 2011. The report also indicated that the physician should consider a gradual dose reduction, if appropriate. If the therapy is to continue at the current dose, provide a rationale describing a dose reduction as clinically contraindicated. The Registered Nurse Case Manager (RNCM) for hospice wrote on the form, "No change at this time", but did not write a rationale On July 12, 2012, at 2:30 p.m. during an interview the evaluator asked the RNCM why the physician did not respond to the pharmacists' recommendation with a rationale for no change in the dosage. The RNCM wrote a rationale indicating the resident complains of anxiety and sleeplessness. He also indicated the resident only sleeps a few hours at night and complains of chronic severe pain. The RNCM indicated the current dose was appropriate for the resident's comfort and sleep pattern. A review of the Medication Record for the months of May and June, 2012, and July 1 to 9, 2012, revealed no documentation to show the resident was monitored for sleeplessness. However, the resident was monitored for restlessness and outbursts of anger and had exhibited no behavior.	F 329		
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	F 371		

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F 371	Continued From page 19 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the kitchen in a clean and sanitary manner. Findings: During the kitchen observation on July 10, 2012, at 9 a.m., the evaluator observed the following: 1. The fan guard inside the four door refrigerator had an accumulation of rust. 2. There was peeling paint around the speaker in the ceiling. 3. There was dust on the wall between the four door refrigerator and the steamer. There was also dust on the back of the steamer. 4. There was an accumulation of dust and grease on the pipes and wall behind the flow circulating heat oven. 5. There was an accumulation of dust, dirt and debris under the oven. 6. There was duct tape on the wall inside the walk-in refrigerator.	F 371	F 371 1.The rusted fan guard was removed and replaced with a new fan guard by maintenance staff. 2.The peeling paint was cleaned up and re-painted by maintenance staff. 3.All dust was cleaned up from the refrigerator and steamer with cleaner by dietary staff. 4.The dust and grease on the pipes and wall behind the flow circulating heat oven was cleaned up with cleaner and brush by dietary staff. 5.The dust, dirt, and debris under the oven was also cleaned with cleaner by dietary staff . 6.The duct tape on the wall inside the walk-in refrigerator was removed by maintenance staff. 7.The company for the juice dispenser came to the facility twice to do deep cleaning. When the company first came in on 7/12 they were unsatisfied with the way the cleaning was done, therefore, the company sent another team on 7/16 to complete the deep cleaning. The company also promised to continue visiting the facility on a monthly basis to continue a deep cleaning process. 8.The stainless steel prep counter and splash guard behind the juice dispenser was cleaned with cleaning agents by dietary staff.	7-11-12 7-11-12 7-10-12 7-10-12 7-10-12 7-11-12 7-12-12 & 7-16-12 7-11-12

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F 371	Continued From page 20 7. The juice dispenser had an accumulation of dust, dirt and debris around the motor. 8. The stainless steel prep counter and splash guard behind the juice dispenser had an accumulation of dust and debris between the splash and the wall. 9. The ventilation fan in the ceiling had a build up of dust. 10. The dishwasher racks had an accumulation of a black substance and dirt. 11. The tray holder had duct tape around the edges. 12. All of the storage carts in the kitchen had accumulation of stains and debris. 13. The ice machine storage room had about 10 water soaked blankets lying on the floor. The floor tiles were stained, cracked and rotting away. The vent above the ice machine had an accumulation of dust. The floor had an accumulation of dust, dirt and debris. There was peeling paint on the wall behind the ice machine. 14. The Janitor Closet had a musty odor and the walls and floor had an accumulation of dust, dirt and debris. 15. The dry storage room housing the emergency food, had an accumulation of dust, dirt and debris on the floor and cobwebs on the wall. The room was also unorganized and in disarray with boxes stacked to the ceiling.	F 371	9.The dust ventilation fan in the ceiling was cleaned by maintenance staff to remove all dust . 10.New dishwasher racks were ordered on 7/11 to replace old dishwasher racks with accumulation of black substance and dirt. The facility is still awaiting delivery. 11.The duct tape around the edges of the tray holder was removed and replaced with rubber sealing to block sharp edges. 12.All storage carts in the kitchen with accumulation of stains and debris were ordered on 7/11. The facility is still awaiting delivery. 13.The blankets lying on the floor in the ice machine storage were cleaned up the day they were found. The maintenance department replaced the broken tiles. The maintenance department also cleaned the vent above the ice machine to remove dust and repainted behind the ice machine. The floor was cleaned by housekeeping staff. Furthermore, dietary staff removed all ice from the ice machine and completed a deep cleaning of the ice machine. 14.The janitor closet was cleaned by housekeeping staff . 15.The dry storage room with emergency food was cleaned to remove dust, dirt, debris, and cobwebs by housekeeping staff. The room was re-organized by dietary staff.	7-11-12 7-11-12 7-11-12 7-11-12 7-18-12 7-13-12 7-19-12

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F 371	Continued From page 21 16. The floor in the room used for storing paper goods had cracked floor tiles, stains, dust, dirt and debris. 17. There was no janitorial sink in the kitchen. According to the Dietary Service Supervisor the staff threw the dirty water in the parking lot after mopping the kitchen floor.	F 371	16.The floor in the room used for storing paper goods was cleaned by housekeeping staff. The tiles were also replaced by maintenance staff. 17.The dietary staff was in-serviced by Dietary Supervisor on proper disposal of dirty mop water .	7-11-12 7-17-12
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	The Dietary Supervisor made rounds to make sure all aforementioned corrective actions were taken and implemented, and no other issues were identified. The Dietary Supervisor will make daily rounds throughout the kitchen to make sure the environment and equipment are clean. The kitchen will be also be monitored by Dietary Supervisor to ensure it is organized throughout each shift. The Dietary Supervisor will perform periodic in-service to dietary staff to make sure all dietary and kitchen policies are followed through. The Administrator will perform random rounds throughout the kitchen to ensure cleanliness and organization.	7-17-12 7-19-12

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F 431	Continued From page 22 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. ensure expired medications, sixty-eight counts of "magic bullets" (bisacodyl 10 mg suppositories, medications used as laxatives), were not available for use in Nursing Station 2; 2. ensure controlled substance count on residents' medical records matched the actual narcotic supplies for two out of two medication carts at Nursing Station 2, affecting at least three residents; 3. ensure nursing staff followed the facility's policy and procedures on inventory control of controlled substance. Findings: a. On July 9, 2012, at 11:17 a.m., during an inspection of the medication room (med room) of Nursing Station 2, the assistant director of nursing (ADON) found six-eight counts of "magic bullets", marked with expiration dates of "5/2012", in the medication refrigerator. A review of the "quality improvement: consultant	F 431	F431 Facility checked all medications and no other expired medications were identified. Facility investigated the surveyors conclusions and found that all the correct medications were given appropriately. Documentation was corrected to reflect this. The DNS checked all narcotic medications and reconciled them with the narcotic count sheet and there were no other discrepancies. No other expired meds were identified. Pharmacy consultant will check Narcotic Count Sheets twice monthly as well as expired medications and report findings to DNS and Administrator. Pharmacy consultant will report to the QA Committee quarterly with summary findings of her audits.	7-10-12 7-10-12

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pharmacist summary", signed by the pharmacist on June 12, 2012, page 2, revealed there was "80-89%" compliance in " out-of-date medications are not available" and the pharmacist" discussed with facility leadership."

A review of the facility policy and procedure, titled "medication storage in the facility", undated, under item "M", "[outdated] medications are immediately removed from stock.

b. On July 9, 2012, at 11:20 a.m., during an inspection of the medication cart 1 for the Nursing Station 2, the charge RN (registered nurse) counted three bubble packs containing a total of 86 counts of hydrocodone/acetaminophen 5/325 (generic for Norco 5/325, a controlled substance used to relieve pain) for Resident 26; however, the controlled drug record showed the last entry on July 8, 2012, at 10 p.m., indicated there should be 90 counts. Resident 26's medication record indicated the last dose (2 tablets) given was at 6 a.m., on July 9, 2012. The staff could not answer why there was a discrepancy.

At 11:40 a.m., during an inspection of the medication cart 2 for the Nursing Station 2, the charge LVN (licensed vocational nurse) presented a bottle containing morphine sulfate (a schedule II controlled drugs for treatment of pain) 20 mg/ml and labeled for Resident 27. LVN made a visual inspection and stated the bottle contained approximately 48 milliliters (ml). The label of the bottle indicated the pharmacy originally dispensed 60 ml on "5-23-12". The perpetual inventory log sheet for the morphine sulfate labeled for Resident 27 indicated the inventory count started at 30 ml with the first dose

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given on May 24 at 11 a.m. and there should be 26 ml remaining. There was no other log sheet for the same medication and resident. The LVN could not explain the discrepancy.

At 12:55 p.m., continuing on the medication cart inspection, the LVN stated there were three patches of 12 microgram (mcg) fentanyl patch (a Schedule II controlled drugs for treatment of pain) and three patches of 75 mcg fentanyl for Resident 6. However, the "perpetual inventory log sheet" for both of the fentanyl strengths indicated there should be 4 patches remaining for the 12 mcg and 4 patches remaining for the 75 mcg patches. The log sheets also indicated the most recent dose administered was on July 9, 2012 at 9 a.m. for both strengths. The LVN stated she remembered the packages were already opened when she administered the patches but she could not answer why she didn't notice the difference in counts.

A review of Resident 6's medication record for July 2012, Resident 6 was to receive fentanyl 87 mcg every 72 hours (i.e. 12 mcg plus 75 mcg patches) and the fentanyl patches were administered on 7/3/12, 7/6/12, and 7/9/2012.

According to the "narcotic and hypnotic inventory sheet", there were three shift counts per day and two nurses were required to perform and document in each shift count. Therefore, at least nine shift counts missed the discrepancy described above.

At 2:40 p.m., during an interview, the DON stated four different staff initialed on the shift count sheet between the period of July 6, 2012 and July

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F 431	Continued From page 25 9, 2012. The DON agreed the nurses performing the shift counts were supposed to count accurately on the narcotics inventory. c. On July 9, 2012, at 11:55 p.m., during an interview, the LVN stated she performed the shift count with the out-going nurse at 7 a.m. of the same date. The LVN presented the "narcotic and hypnotic inventory sheet" and pointed out her initial. The LVN admitted she and the out-going nurse did not do a thorough count. There was no evidence that the discrepancies mentioned above had been resolved. At 2:40 p.m., during an interview, the DON agreed the nurses performing the shift counts were supposed to count accurately on narcotics inventory. At 3:30 p.m., the DON stated an in-service had been provided to the staff on April 16, 2012 and May 31, 2012, on topics including expired medications and shift counts. On 7/10/2012, at 11:30 a.m., during a telephone interview, the consultant pharmacist stated she noticed the inconsistency in controlled substances documentation and had reported to the facility's leadership in her monthly visit report. A review of the facility's policy and procedure, adopted from Omnicare, Inc., titled "Inventory control of controlled substances", dated May 1, 2010, facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift reconcile the total number of controlled	F 431		

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F 431	Continued From page 26 medication on hand and reconcile the number of doses remaining in the package to the number of remaining doses recorded on the [count sheet]." According to the same policy and procedure, the facility should also conduct an investigation to determine whether a dose was administered, the reason the administration was not charted and whether a dose was refused. A review of another facility's policy and procedure, adopted from Omnicare, Inc., titled "General Dose Preparation and Medication Administration", dated 5/01/10,". After medication administration, facility staff should document necessary medication administration information on appropriate forms. Referencing the applicable regulatory requirement listed under California Code of Regulation, Title 22, section 72369 (b), the records of use for all Schedule II drugs "shall be maintained accurately" and the inventory of controlled drugs are readily traceable.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 27 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to establish an infection control program for cleaning, disinfecting, and storing of residents' care equipments to prevent the potential of cross contamination and the potential to spread infection, and failed to maintain acceptable temperatures for processing the linen. Findings: During the initial tour of the facility on July 9,	F 441	F441 Facility immediately checked rooms and properly placed urinals in sanitary locations. Laundry staff was instructed to maintain dryer temperatures at 180 degrees. DSD performed rounds and in-serviced staff on the proper placement of urinals. Housekeeping supervisor checked dryer temperatures and they were found to be in compliance. DSD will periodically round with DNS to ensure compliance with facility sanitation policies. Housekeeping Supervisor will periodically check dryer temperatures to ensure compliance. DSD, DNS, and Housekeeping Supervisor will report sanitation issues to the Administrator.	7-9-12 7-9-12 7-13-12

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F 441	Continued From page 28 2012, from 8:30 a.m. to 10 a.m., the following was observed: a. In Room 44 a canister for urine collection was on the floor with no identification . b. In Room 45-B were two dirty containers stored on top of the bedside drawer not labeled. The Director of Nursing (DON) was not able to identify what those containers were used for and on which resident. There were three residents in the room. c. A urinal was on the bathroom floor with no identification in Room 50. d. In Room 51 bathroom had a urinal on the floor with inscription bed B. e. In Room 53 bathroom had a bed pan and urinal on the floor with no identification. On the same day during an interview with the DON, she stated that containers, bedpans and urinals should be labeled with room # and bed # for identification to prevent cross contamination. According to the facility undated policy titled "Labeling Equipment" indicated upon admission, certified nursing assistants will mark all basin, urinals, and bedpan, with the resident's name. Also, Licensed nurses will make daily rounds to ensure those equipment are labelled. h. On July 13, 2012, at 11 a.m., during an observation of the laundry room, one of the washers only reached 128 degrees Fahrenheit. During the observation of the laundry, feces could be seen inside the washer through the glass on	F 441		

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F 441	Continued From page 29 the door during the wash cycle. The facility had several residents in isolation. According to the California Uniform Plumbing Code, Section 1011-1012, page 95.1, The required temperature of 160 degrees Fahrenheit in the laundry is that measured in the washing machine and shall be supplied so that the temperature may be maintained over the entire wash and rinse period. A lower temperature of 140 degrees Fahrenheit may be utilized, provided linens are subsequently passed through a tumbler dryer at 180 degrees Fahrenheit or a flatwork ironer at 300 degrees Fahrenheit.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the environment in a clean and sanitary manner. Findings: During a general observation of the facility on July 13, 2012, the following was observed: Station 1 1. The cabinet under the sink in the utility room had stains and was rotting away.	F 465	F465 1.Facility painted cabinets under the sink in Station I Utility Room. 2.The storage room ceiling, housing near the crash cart, has been painted. 3.The medical Records Storage room has been cleaned. 4. The Facility has scheduled a date to paint and fix the walls in the water heater room. 5. The area behind the laundry has been cleaned an organized. 6. The vents were cleaned in the staff lounge. 7. The shelves in the chemical storage room will be replaced when the shelving is received. 8. The plaster in the oxygen room has been repaired.	7-16-12 7-16-12 7-13-12 7-16-12 7-16-12 7-13-12 7-16-12 7-16-12

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F 465	Continued From page 30 2. The storage room housing the crash cart had peeling paint on the ceiling around the light fixture. 3. The medical records storage room had a large amount of dust dirt and debris on the floor. 4. The room housing the water heater had peeling plaster on the wall and an accumulation of dust, dirt and debris. 5. The area behind the laundry room (used for storing dirty clothes barrels) had approximately five storage carts outside that had an accumulation of dust, dirt and debris. 6. The staff lounge had an accumulation of dust in the vents. 7. The shelves inside the chemical storage room were rotting away and had an accumulation of dust dirt and debris. Station 2 8. The oxygen tank storage room had an accumulation of dust, dirt and debris on the floor and peeling plaster on the wall. 9. The social service storage room had an accumulation of dirt and debris on the floor. The light was not working. 10. The ventilation fan was not working in the shower room next to room 41. 11. The dietary storage room had cracked floor tiles that were coming up from the floor. There was also peeling plaster and debris on the floor.	F 465	9. Housekeeping cleaned the social service storage room and maintenance replaced the light bulb. 10.The ventilation fan was repaired in the shower room next to room 41. 11.The dietary storeroom was thoroughly cleaned and the tiles will be repaired. 12. The floor inside the cabinets in the rehabilitation room has been cleaned. 13.Housekeeping staff were in-serviced to use the appropriate sinks to discard dirty water. The Housekeeping Supervisor and Maintenance supervisor performed rounds and found that other facility areas were clean and in good working order. The Housekeeping Supervisor and Maintenance supervisor will make rounds periodically and identify facility areas that need cleaning and / or repair. The Housekeeping Supervisor and Maintenance supervisor will report areas of concern to Administrator as needed.	7-13-12 7-16-12 7-15-12 7-13-12 7-13-12

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F 465	Continued From page 31 12. The floor inside the cabinets had an accumulation of dirt, dust and debris in the rehabilitation room. 13. The housekeeping staff were using the hopper in the utility room to dump the dirty mop water and retrieve clean water instead of using the janitorial sink that was designed for that purpose.	F 465		