STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. BUILDING _____ B. WING _____	12/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS PALOS CONVALESCENT HOSP	1430 WEST 6TH STREET SAN PEDRO, CA 90732

Annie Woods
Digitally signed by Annie Woods
DN: cn=Annie Woods, o=West District Office, ou=HFID, email=awoods@cdph.ca.gov, c=US
Date: 2013.02.26 15:40:19 -08'00'

(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: 11912, RN, HFEN 06646, REHS, HFE I 25048, RN, HFEN 30838, RN, HFEN Total population: 82 Sample size: 17 Highest scope and severity: E	F 000	Los Palos Convalescent Hospital submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the provider of its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that a resident/surrogate's right to formulate an advance directive was updated to reflect resident's/surrogate's wishes to be full code. This was evident for two of 17 sample residents (Resident 1 & 9). Residents 1 and 9's surrogates completed a Physician Orders for Life-Sustaining Treatment (POLST) to change from "do not attempt	F 155	**F155 483.10 (b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVE** **Corrective Action for Affected Resident** The attending physicians for Residents 1 & 9 were immediately notified of the residents' new code status on 12/10/2012, physician's orders were	

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: CP Waldman | TITLE: ADMINISTRATOR | (X6) DATE: 1/28/2013

eficiency 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 ng 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 ollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued m participation.

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F 155	Continued From page 1 resuscitation" (DNR [allow natural death]) to a "full code" status (attempt to revive). However, both residents' clinical records were not updated. The failed practice of the facility to not update Residents 1 & 9's code status could potentially cause withholding treatment and not performing cardiopulmonary resuscitation (CPR) in the event the resident coded (a resident whose heart has stopped beating). Findings: a. On December 5, 2012, a review of Resident 9's clinical record (Face Sheet) indicated the resident was admitted to the facility on November 24, 2011. Resident 9's diagnoses included dementia (loss of brain function that affects memory, thinking, language, judgment, and behavior). The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated on September 6, 2012, indicated Resident 9 had the ability to understand others and made self-understood. According to the MDS, the resident was totally dependent on staff for activities of daily living (ADLs) such as, dressing, transferring, personal hygiene, and toilet use. A review of the Physician Orders for Life-Sustaining Treatment (POLST) dated on October 11, 2012, indicated Resident 9's surrogate requested to have Resident 9 on full code. A review of the recapitulated Physician Orders for the months of November and December 2012	F 155	obtained and the clinical records were updated to reflect the change. **Procedure for Identifying Potentially Affected Residents and Corrective Action** Social Services Designee and Medical Records Director conducted a joint review of all residents' clinical records to ensure that the clinical records reflect the current code status of the residents. No other resident is affected by similar concern. **Measures Adopted to Prevent Recurrence** The Director of Nurses gave, an in-service to all licensed nurses and Medical Records Staff on 12/11/2012 on informing the attending physician and updating the clinical records for any changes in the residents' code status. Changes in any resident's code status will continue to be discussed and communicated during the daily stand-up meeting and endorsement meetings. Medical Records staff will continue their daily audit of clinical records and physician's orders to ensure that changes in the residents' code status are reflected in the clinical records on an accurate and timely basis. **Monitoring of Corrective Action and Quality Assurance**	1/18/2013

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F 155	Continued From page 2 indicated the resident was still a DNR and never got updated to full code. b. A review of Resident 1's clinical record indicated the resident was admitted to the facility on February 21, 2012, with diagnoses that included Parkinson's disease (degenerative disorder of the central nervous system) and chronic obstructive pulmonary disease (persistent obstruction of the airways). A review of the Physician Orders dated February 22, 2012, indicated the resident requested a do not attempt resuscitation (DNR). A review of the Social Work Progress Notes dated October 29, 2012, no time indicated, documented during an interview with Resident 1, the resident requested to update his POLST to attempt resuscitation (full code). A review of the Physician Orders for Life-Sustaining Treatment (POLST) dated October 29, 2012, indicated the resident was changed to full code. However, there was no change in the physician's order for Resident 1's code status. During an interview with the social service designee on December 6, 2012 at 12:30 p.m., she stated when there is a change in the POLST; nursing is to notify the physician. However, this was not done. The facility policy and procedure titled, "Do Not Resuscitate Order", dated August 2006, indicated the attending physician must be informed of the resident's request to case the DNR order.	F 155	The Medical Records Director will provide a summary trend analysis of the findings from their clinical records audit to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations. Completion date January 18, 2013	

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's licensed staff failed to notify	F 157	**F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/ DECLINE/ ROOM, ETC)** **Corrective Action for Affected Resident** Resident 5 was immediately re-assessed. Resident 5's socks were removed and resident's lower extremities feet were elevated to promote comfort and circulation. MD was notified of the concern and ordered a Doppler study. Doppler study result dated 12/11/2012 indicated no evidence of DVT (Deep Vein Thrombosis). Resident's care plan was updated to reflect the plan of care provided to the resident. **Procedure for Identifying Potentially Affected Residents and Corrective Action** Treatment Nurse and Director of Staff Development checked all resident's lower extremities on 12/11/2012 to ensure that no similar concern affects other residents. No other concern was identified. **Measures Adopted to Prevent Recurrence** The DON gave an in-service to all licensed nurses on 12/11/2012 regarding regulation and facility protocol on	1/18/2013

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F 157	Continued From page 4 the resident's physician and responsible party regarding indentation marks to the resident's lower extremities due to tight socks for one of 17 sampled residents (Resident 5). This deficient practice had the potential for the resident not receiving prompt and appropriate treatment and does not promote resident's/responsible party's right to be informed of changes in the resident's condition. Findings: A review of Resident 5's admission records indicated she was admitted to the facility on November 19, 2012, with diagnoses including diabetes (disease that affects how the body use blood sugar), pressure ulcer Stage II (tissue damage caused by prolonged pressure), and dementia (brain disorder). A Minimum Data Set (MDS), a standardized assessment care tool, dated November 26, 2012, indicated the resident had short and long term memory problems, and needed extensive assistance with bed mobility, transfers, dressing, personal hygiene, and bathing. An interview and record review with the director of nursing (DON) on December 6, 2012 at 3:45 p.m., there was no documentation of physician and responsible party notification regarding the indentation marks on the resident's bilateral lower extremities as observed during provision of shower on December 6, 2012 at 10 a.m. At the time of the incident, the DON and Licensed Vocational Nurse 7 (LVN 7) stated the physician would be notified of the incident. The DON stated	F 157	notification of resident's physician and responsible party. QA Nurse and Medical Records will continue to review all SBAR forms for any change of condition to ensure that all noted changes are communicated to MD and all protocols and required documentation are put in place. DON and/or Designee will continue to conduct routine review of residents' medical records to ensure that any noted changes to residents are relayed to the physician and responsible party and documented in the chart. **Monitoring of Corrective Action and Quality Assurance** The Director of Nurses will provide a summary trend analysis of the findings from their clinical records audit to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations. **Completion date** January 18, 2012	

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F 157	Continued From page 5 she did not check pedal pulse (throbbing of the arteries indicating circulation to the lower extremities) to the resident's lower extremities. A review of the Licensed Nurses Notes, dated December 6, 2012 at 10 a.m., 12:50 p.m., 1:50 p.m., and 3:15 p.m., did not indicate the resident's physician was notified of the multiple indentation marks to the resident's lower extremities due to the tight socks. The marks on the resident's lower extremities was documented in the clinical record on December 7, 2012 at 2:10 p.m. after this was brought to the staff attention on December 6, 2012. However, there was no documentation indicating the resident's responsible party or the physician had been notified of the incident. An interview and record review was conducted on December 10, 2012 at 8:45 a.m., with the DON concerning the resident's responsible party not notified of the incident, she had no comment. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, dated April 2007, indicated the nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there had been an accident or incident involving the resident, and a discovery of injuries of an unknown source.	F 157		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	**F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES** **Corrective Action for Affected Resident** The mattress in Room 121 was immediately removed on 12/5/2012 from the room and replaced with another mattress. No other concern was noted afterwards.	1/18/2013

Procedure for Identifying Potentially Affected Residents and Corrective Action

IDT members made environmental rounds to identify other residents who may be potentially affected by similar concern. No other concern was identified.

Measures Adopted to Prevent Recurrence

DSD gave an in-service on 12/11/2012 to nursing staff regarding immediate reporting of any concern on housekeeping and maintenance services.

Physical Plant Designee re-educated housekeeping and janitorial staff on 12/11/2012 regarding policy on bed disinfection to ensure that resident's beds are free of urine odor.

IDT members and nursing staff will continue to ensure that environment is safe and comfortable during their daily rounds and concerns are reported and addressed on a timely basis.

Monitoring of Corrective Action and Quality Assurance

The Physical Plant Manager/Designee and Director of Staff Development will provide a summary trend analysis of the environmental rounds findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.

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F 253	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a resident's bed was free from strong urine odor. There was a strong urine odor in Room 121. This deficient practice had the potential to spread disease causing organisms. Finding: On December 3-5, 2012, during the survey, there was a strong urine odor observed in Room 121. On December 5, 2012, at 9:00 a.m., during an observation of a staff changing Bed B's linen, the strong urine odor was coming from the mattress. On December 5, 2012, at 9:30 a.m., during an interview with the maintenance supervisor, he stated he would change the mattress.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	**F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Corrective Action for Affected Resident** a. Resident 5 was immediately re-assessed. Resident 5's socks were removed and resident's lower extremities feet were elevated to promote comfort and circulation. MD was notified of the concern and ordered a Doppler study. Doppler study result dated 12/11/2012	1/18/2013

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F 279	Continued From page 7 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's licensed staff failed to develop comprehensive care plans for two of 17 sampled residents (Residents 5 and 14). This deficient practice had the potential for non-continuity of care. Resident 5 had no plan of care for monitoring the use of tight socks causing indentation and edema (swelling) to the lower extremities that could potentially cause circulatory compromise. Resident 14 had no care plan for monitoring of the resident's arteriovenous (AV) shunt (a surgically created connection between an artery and a vein to provide vascular access for hemodialysis, a treatment that cleans the blood by removing wastes and excess water from the body). Resident 14's care plan did not specify monitoring of the resident's fluid restriction (amount of fluid that can be taken in a 24 hour period by the resident as ordered by the physician as part of the treatment). This deficient practice had the potential to cause accumulation of excess fluid in the body between hemodialysis treatments causing edema (swelling), increased blood pressure, and difficulty breathing.	F 279	indicated no evidence of DVT (Deep Vein Thrombosis). Resident's care plan was updated to reflect the plan of care provided to the resident. b. Resident 14's AV shunt was checked and no bleeding or swelling noted, bruit and thrill present. Resident's care plan was updated on 12/7/2012 to include monitoring of the resident's AV shunt and care to be provided to the resident's left hand/arm including no blood or lab draw instructions. c. Resident 14's clinical records were reviewed and a physician's order was obtained on 12/7/2012 to monitor resident's fluid intake. The resident's care plan was updated to include specific amount of fluid that could be taken by the resident to prevent fluid overload. **Procedure for Identifying Potentially Affected Residents and Corrective Action** a. Treatment Nurse and DSD checked all resident's lower extremities to ensure that no similar concern affects other residents. No other concern was identified.	

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F 279	Continued From page 8 Findings: a. A review of Resident 5's admission records indicated she was admitted to the facility on November 19, 2012, with diagnoses including diabetes (disease that affects the body's use of blood sugar), pressure ulcer Stage II (tissue damage caused by prolonged pressure), and dementia (a brain disorder). A Minimum Data Set (MDS), a standardized assessment care tool, dated November 26, 2012, indicated the resident had short and long term memory problems, and needed extensive assistance with bed mobility, transfers, dressing, personal hygiene, and bathing. During a shower observation on December 6, 2012 at 10 a.m., the certified nursing assistant (CNA 5) removed the long socks from Resident 5's lower extremities. Both lower extremities had multiple deep indentation marks and edema. The resident stated she had pain in her legs. The director of nursing (DON) assessed the resident's extremities at that time and stated she did not feel a pedal pulse. The licensed vocational nurse (LVN 7) was called to observe the indentation marks and stated she would notify the physician. After Resident 5's shower, CNA 5 went to get clean socks from the clean linen cart and put it on the resident's feet. CNA 5 stated socks were shared among the residents. The socks from the linen cart looked the same as the one taken off, long white tube socks. During an interview and record review with the	F 279	b. Treatment Nurse and DSD checked the AV shunts of all residents receiving dialysis treatments to ensure that no similar concern affects other residents. No other concern was identified. c. Clinical records of residents on dialysis and those with order for fluid restrictions were reviewed to ensure that physician's orders and care plans are in place to address monitoring of the resident's fluid intake. No other concern was identified. **Measures Adopted to Prevent Recurrence** On or before 1/18/2012, the DON will re-educate all licensed nurses about the policies and procedures on development, review, and revision of resident's comprehensive plan of care. The DON/designee and QA Nurse will continue to conduct admission/quarterly/PRN review of resident's clinical records to ensure that identified needs of the residents have appropriate plans of care. Daily Telephone Order Audit by Medical Records includes verification that the resident care plan reflects the current medication/treatment regimen rendered to the resident.	

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F 279	Continued From page 9 DON on December 6, 2012 at 3:30 p.m., there was no care plan developed to address the use of socks during the night. The DON stated the staff were not to leave socks on the residents at night. On December 10, 2012 at 8:30 a.m., while sitting in the activity room, Resident 5's right lower extremity was observed to have indentation marks. The restorative nurse assistant (RNA 1) stated she would change the resident's socks to her right leg. An interview with the DON at the time, she stated the resident was checked previously and there was no indentation marks to her leg. On December 7 and 10, 2012, during a review of Resident 5's care plans, there was no care plan developed to address monitoring of the resident's circulation to the lower extremities due to the use of socks at night. b 1. A review of Resident 14's admission records indicated he was admitted to the facility on November 30, 2012, with diagnoses including end stage renal disease on hemodialysis, and diabetes mellitus Type II (disease affecting how body uses blood glucose). The resident had an AV shunt to his left upper arm. A review of the Minimum Data Set (MDS), a standardized assessment tool, dated December 1, 2012, indicated the resident's cognitive skill was impaired and needed maximum assist to get out of bed to a wheelchair. On December 7, 2012 at 9 a.m., during review of Resident 14's clinical records, there was no care plan developed to address monitoring of the	F 279	**Monitoring of Corrective Action and Quality Assurance** The Director of Nursing and/or designee will provide a summary trend analysis of the findings clinical records audit and Medical Records audits to the Administrator and Quality Assurance and Performance Improvement Committee for further evaluation and recommendations.	

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F 279	Continued From page 10 resident's AV shunt. A review of the Medication Administration Record (MAR) did not include monitoring of the resident's AV shunt and care to the left hand/arm including no blood or lab draws. The resident had been in the facility for seven days. During an interview and record review on December 7, 2012 at 10:15 a.m., LVN 5 stated the staff document monitoring in the MAR however, he had no comment why there was no monitoring of the AV shunt in the MAR. During an interview on December 7, 2012 at 2:50 p.m., the director of nursing (DON) did not give a comment why monitoring of the AV shunt was not addressed. b 2. A review of Resident 14's clinical record indicated there was no plan of care to address monitoring the resident's fluid intake due to his diagnosis of end stage renal disease and was receiving hemodialysis three times a week (Tuesday, Thursday, and Saturday). A review of the MAR did not include monitoring of the resident's fluid intake. During the medication pass on December 5, 2012 at 10:35 a.m., LVN 4 stated there was no monitoring for fluid restriction for Resident 14. The resident was admitted to the facility on November 30, 2012, a total of five days. A review of the plan of care for chronic renal failure, dated November 30, 2012, indicated the resident was at risk for edema, fluid overload, and electrolyte imbalance. However, the care	F 279		

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F 279	Continued From page 11 plan did not specify the amount of fluid that could be taken by the resident to prevent fluid overload. The physician's order was not obtained until December 5, 2012, five days after his admission to the facility. An interview with the registered nurse (RN 2) on December 5, 2012, at 11 a.m., she stated the resident was only admitted to the facility for five days. RN 2 did not comment how soon a physician's order for fluid restriction was to be obtained. RN 2 stated she would call the dialysis unit to find out the amount of the fluid restriction and then call the physician to obtain an order. A review of the facility's policy and procedure titled, "Care Plans Comprehensive", dated August 2006, indicated each resident's comprehensive care plan has been designed to incorporate identified problem areas, and risk factors associated with identified problems.	F 279		
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 interview and record review, the facility's licensed staff failed to ensure one of 17 sampled residents (Resident 14), arteriovenous	F 309	**F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Corrective Action for Affected Resident** Resident 14's AV shunt was checked and no bleeding or swelling noted, bruit and thrill present. Resident's care plan was updated to include monitoring of the resident's AV shunt and care to be provided to the resident's left hand/arm including no blood or lab draw instructions. MAR now includes monitoring of AV shunt by licensed staff qshift.	1/18/2013

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F 309	Continued From page 12 shunt (AV shunt, a surgically created connection between an artery and a vein to provide access during hemodialysis, a treatment that cleans the blood by removing wastes and excess water from the body) on the left arm was assessed and monitored every shift for proper function according to the facility policy and procedure. This deficient practice had the potential risk for unrecognized unwanted signs and symptoms and delayed provision of treatment/care. Findings: A review of Resident 14's admission records indicated he was admitted to the facility on November 30, 2012, with diagnoses including end stage renal disease on hemodialysis and diabetes mellitus Type II (disease affecting how body uses blood glucose). The resident had an AV shunt to his left upper arm. A review of the Minimum Data Set (MDS), a standardized assessment tool, dated December 1, 2012, indicated the resident's cognitive skill was impaired and needed maximum assist with transfers out of bed to the wheelchair. On December 7, 2012 at 9 a.m., a review of Resident 14's Medication Administration Record (MAR) did not indicate monitoring of the AV shunt site for presence of bruit and thrill, and signs/symptoms of bleeding or infection. The resident had been admitted to the facility for seven days. From December 3 to December 7, 2012 at 4 p.m., there was no precautionary sign in the	F 309	Precautionary sign is now in place in the resident's room to indicate no drawing of blood for labs or obtaining blood pressure on the left hand/arm. **Procedure for Identifying Potentially Affected Residents and Corrective Action** On 12/12/2012, DON and Medical Records Director reviewed clinical records of all residents receiving dialysis treatment to ensure that monitoring of the AV shunt is performed and documented per shift and as needed, and that precautionary signs are in place to indicate no drawing of blood for labs or obtaining blood pressure on the left/hand/arm. No other concern was identified. **Measures Adopted to Prevent Recurrence** On or before 1/18/2012, the DON will re-educate all licensed nurses and medical records staff on facility policy re: monitoring the AV Shunt. Nursing Leadership team will continue to monitor compliance during their clinical and endorsement rounds. Any negative findings will be corrected immediately and reported to the Director of Nursing for further action. **Monitoring of Corrective Action and Quality Assurance**	

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F 309	Continued From page 13 resident's room to indicate no drawing of blood for labs or obtaining blood pressure on the left hand/arm. During an interview on December 7, 2012 at 10: 15 a.m., licensed vocational nurse (LVN 5) stated labs should not be drawn and blood pressures should not be taken on the resident's arm where the AV shunt was placed. LVN 5 stated he thought there was a sign over Resident 14's bed as seen with other dialysis residents, but there was none. LVN 5 stated the staff document monitoring in the MAR however, he had no comment why there was no monitoring of the AV shunt. During an interview on December 7, 2012 at 2:50 p.m., the director of nursing (DON) did not give a comment why monitoring of the AV shunt was not addressed. A review of the facility's policy and procedure titled, "Monitoring of AV Shunt", dated April 2006 indicated during daily rounds every shift made sure bruit by auscultation and thrill by palpitation was working, check for signs of bleeding, no blood pressure or IV (intravenous) on the side of the AV shunt, and to record the presence of bruit and thrill.	F 309	The Director of Nursing will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Performance Improvement Committee for further evaluation and recommendations. **F311 483.25 (A)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS** **Corrective Action for Affected Resident** On 12/6/2012, the speech therapist immediately came to evaluate Resident 2 with a subsequent recommendation to continue regular diet as ordered. Resident has been able to tolerate regular diet well. **Procedure for Identifying Potentially Affected Residents and Corrective Action** All residents with order for speech evaluation for the one month prior to December 10, 2012 were reviewed by the Nursing Supervisor and Medical Records Director to ensure that speech evaluation was done and results were followed up and documented in the clinical records. No other concern was identified. **Measures Adopted to Prevent Recurrence** DON gave a one-on-one in-service on 12/11/2012 to the licensed nurse who wrote the order about ensuring that orders received for referrals such as	1/18/2013
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		

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F 311	Continued From page 14 by: Based on interview and record review, the facility failed to provide speech evaluation for one of 17 sampled residents (2) according to physician's order. This had the potential to result in a delay in treatment. Findings: A review of the clinical record for Resident 2 indicated the resident was readmitted to the facility on April 20, 2012, with diagnoses that included cerebrovascular accident (stroke), right side weakness, and dysphagia (difficulty in swallowing). The Physician's Progress notes had physician's documentation dated November 27, 2012, indicating the resident had her gastrostomy (a tube surgically placed through the abdomen wall and into the stomach for feeding) tube removed on November 21, 2012, and the resident's diet was upgraded to regular diet. A chest x-ray and a speech re-evaluation were ordered. On November 29, 2012, the physician ordered a chest x-ray and to follow up with the speech re-evaluation. Further review of the clinical record, there was no results of the speech re-evaluation on file. During an interview and record review with a licensed vocational nurse (LVN 1), she was not able to explain why the speech re-evaluation was not done.	F 311	referrals for speech evaluation should be carried out and followed up completely. This was followed up by an in-service to all licensed nurses on 12/11/2012 emphasizing the importance of ensuring that all orders for referrals should be carried out and followed up completely. Medical Records will continue to conduct daily audit of telephone/physician's orders which will include verification that all referrals have been done and documented in the clinical records. QA Nurse will review the daily telephone order audit. During the daily stand up meeting, all referrals for speech evaluation will be discussed and followed up. **Monitoring of Corrective Action and Quality Assurance** The Director of Nurses will provide a summary trend analysis of the findings from their clinical records audit to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	**F314 483.25 (c) TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES** **Corrective Action for Affected Resident** a. On 12/10/2012, Resident 9's was turned and repositioned	

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F 314	Continued From page 15 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility's staff failed to ensure two of 17 sampled residents (Residents 9 & 10), who were high risk for developing pressure sores (persistent redness to the skin and or break in the skin due to prolonged pressure on the site) or had existing pressure sore, were turned and repositioned at least every two hours. This deficient practice had the potential to cause development of new pressure sores or impede the healing of existing pressure sore. Findings: a. During observations on December 4, 2012, from 11:20 a.m. until 3:42 p.m., Resident 9 was observed on her back in bed with her head elevated approximately 45 degrees. Resident 9 was observed in the same position for more than four hours. During observations on December 5, 2012, from 8:35 a.m. until 10:50 a.m., Resident 9 was observed on her left side. A review of Resident 9's Transfer Record dated	F 314	immediately & re-assessed by the Treatment Nurse and the DON. Resident's sacro-coccyx area was clean and pressure sore appeared to be improving. Direct caregivers were immediately given a one-on-one instruction to ensure turning and repositioning is done pursuant to the resident's care plan. b. Resident 10 was turned and repositioned immediately and re-assessed by the Treatment Nurse and DON and found no new skin problem. Resident's pressure sore at both side of foot and the discoloration in his buttocks area appear to be in stable condition. Direct caregivers were immediately given a one-on-one instruction to ensure turning and repositioning is done pursuant to the resident's care plan. **Procedure for Identifying Potentially Affected Residents and Corrective Action** All residents are likely to be affected by the deficient practice. IDT members made rounds to ensure that the turning schedule is being followed for residents who need assistance in turning and repositioning, especially those who are identified to be high risk. **Measures Adopted to Prevent Recurrence**	

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F 314	Continued From page 16 on December 5, 2012, indicated the resident had a Stage II pressure sore (partial thickness skin loss involving epidermis, dermis, or both [top layers of the skin]) at the sacrococcyx area (tailbone). A review of Resident 9's clinical record (Face Sheet) indicated the resident was admitted to the facility on November 24, 2011. Resident 9's diagnoses included dementia (loss of brain function that affects memory, thinking, language, judgment, and behavior). The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated September 6, 2012, indicated Resident 9 had the ability to understand others and made self-understood. According to the MDS, the resident was totally dependent on staff for activities of daily living (ADLs), such as, dressing, transferring, personal hygiene, and toilet use. A review of Resident 9's plan of care for slow healing ulcer wound dated October 16, 2012, indicated the resident was at risk for delayed healing due to incontinence (unable to control bowel and bladder), history of previous pressure sores, poor bed mobility, and bedfast with total assist needed during ADL's indicated a nursing approach to reposition the resident every two hours. b. During observations on December 4, 2012, from 10:00 a.m. until 2:25 p.m., Resident 10 was observed on his right side with pillows tucked underneath and his head elevated approximately 45 degrees. Resident 10 was observed in the same position for more than four hours.	F 314	Director of Staff Development gave a one-on-one counseling to the direct caregivers assigned to both residents on the days identified herein. On or before January 18, 2013, DSD will also conduct follow-up in-services to all direct caregivers about the importance of turning and repositioning high risk residents. DSD and Treatment Nurse will make periodic announcement of the turning schedule via walkie- talkies (earpiece device provided to staff that allows them to communicate with each other). This announcement will remind direct caregivers to turn and reposition residents. Announcement will be followed up by rounds to verify compliance. **Monitoring of Corrective Action and Quality Assurance** Treatment Nurse and DSD will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	1/18/2013

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F 314	Continued From page 17	F 314		

During observation on December 5, 2012, from 8:40 a.m. until 12:45 p.m. Resident 10 was observed on his left side with pillows tucked underneath, and his head elevated approximately 45 degrees. Resident 10 was observed in the same position for more than four hours.

A review of Resident 10's clinical record (Face Sheet) indicated the resident was admitted to the facility on February 3, 2011. Resident 10's diagnoses included encephalopathy (disease of the brain).

The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated October 27, 2012, indicated Resident 10 was non-verbal and needed total assistance from staff with his activities of daily living including dressing, bathing, and personal hygiene. According to the MDS, the resident required two-person assist in transferring and repositioning.

A review of Resident 10's pressure sore risk assessment dated October 27, 2012, indicated the resident had a score of nine (a total score of 12 or less represents high risk).

A review of Resident 10's plan of care for pressure sore (Stage 4, full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule) at both side of foot dated November 12, 2012, indicated the resident was at risk due to poor bed mobility, anemia (low red blood cell count), and history of previous ulcers included in the approaches was to reposition the resident every 2 hours or as

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F 314	Continued From page 18 needed. A review of the License Nurse's Notes dated December 3, 2012, indicated Resident 10 developed a new induration hard mass with red discoloration, size measured 4.5 x 6 centimeters on the left buttock. On December 6, 2012, at 2:30 p.m., during an interview, the certified nursing assistant (CNA 1) stated, "The resident requires two people to turn him; sometimes we are short of staff." When asked what the facility's policy on turning residents who are bed bound, CNA 1 stated, "Every two hours." A review of the facility's policy titled, "Repositioning", revised April 2007 indicated repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. The policy also indicated residents who are in bed should be on an every 2 hour turning program.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F323 483.25 (h) FREE OF ACCIDENT HAZARDS /SUPERVISION /DEVICES** **Corrective Action for Affected Resident** One-on-one in-service was given by the DON to LVN 6 on 12/11/2012 regarding ensuring that no medication should be left on top of the cart unattended.	

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F 323	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility nursing staff failed to ensure the resident environment remained free of accident hazards by leaving prepared medications on top of the medicine cart, out of direct view of the staff. This deficient practice had the potential risk for confused residents having access to the medications and cause harm. Findings: On December 5, 2012, an observation of the 5 p.m. medication pass was conducted. a. The licensed vocational nurse (LVN 6) prepared Resident 3's medications. LVN 6 left the prepared medications on top of the medication cart, went to the residents' bathroom to wash her hands. b. LVN 6 then prepared Resident 4's medications, left the prepared medications on top of the medication cart, went to the residents' bathroom to obtain paper towels. During an interview with LVN 6 on December 5, 2012 at 5:45 p.m., the nurse gave no answer when it was pointed out the medications were out of visual site twice during the medication pass. The facility policy and procedure titled, "Preparation for Medication Administration" without a date, indicated no medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications.	F 323	**Procedure for Identifying Potentially Affected Residents and Corrective Action** All residents are likely to be affected by the deficient practice. On or before 1/18/2013 the DSD & Pharmacy Consultant will conduct medication pass observation on licensed nurses to identify any deficient practices, especially that which concerns medication storage and safety. **Measures Adopted to Prevent Recurrence** Pharmacy Consultant gave an in-service to all licensed nurses on 12/18/2012 regarding the importance of securing medication cart and not leaving medication on top of the cart unattended. DON, DSD, QA nurse and the Pharmacy Consultant will continue to conduct random and scheduled medication pass observation to ensure that licensed nurses are observing safety procedures and not leaving prepared medication on top of the cart unattended. **Monitoring of Corrective Action and Quality Assurance** DON and DSD will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	1/18/2013
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328	**F328 483.25 (K) TREATMENT/CARE FOR SPECIAL NEEDS**	

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F 328 SS=D	Continued From page 20 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's licensed staff failed to ensure physician's order was obtained for the administration of oxygen for one 17 sampled residents (Resident 14). This deficient practice had the potential risk for the development of adverse reactions from oxygen therapy. Findings: A review of Resident 14's admission records indicated he was admitted to the facility on November 30, 2012, with diagnoses including end stage renal disease (kidneys unable to remove waste products from the body) on hemodialysis (removal of toxic waste products from the kidneys). A review of the Minimum Data Set (MDS), a standardized assessment tool, dated December 1, 2012, indicated the resident's cognitive skill	F 328	**Corrective Action for Affected Resident** Resident was re-assessed immediately. O2 sat level was 96. Resident 14 have occasional complaints of shortness of breath. MD was notified and ordered to administer oxygen at 2 liters via nasal canula PRN. **Procedure for Identifying Potentially Affected Residents and Corrective Action** All residents receiving oxygen were reviewed by the Nurse Supervisor on 12/11/2012 to ensure that there is a physician's order in place for the treatment. **Measures Adopted to Prevent Recurrence** On 12/11/2012, DON gave an in-service to all licensed nurses on ensuring that physician's order is obtained for the administration of oxygen and the potential risk for the development of adverse reactions from oxygen therapy. All residents with physician's order for Oxygen therapy are listed on the facility's Roster Matrix (a spreadsheet document that provides a list of special needs and snapshot of resident information). Facility will reinforce use of the Roster Matrix during daily rounds and QA audit of the charts to ensure that medication/treatment such as administration of oxygen are only given pursuant to a physician's order.	1/18/2013

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F 328	Continued From page 21 was impaired and needed maximum assistance from staff to get out of bed to a wheelchair. During observations on December 3, 2012 at 12:15 p.m., and December 6, 2012 at 9:20 a.m., Resident 14 was receiving oxygen via nasal cannula at 2 liters per minute. A review of the admission physician's orders, dated November 30, 2012, there was no order for oxygen. During an interview on December 7, 2012 at 9:15 a.m., the licensed vocational nurse (LVN 5) stated he did not know if oxygen was ordered for the resident. LVN 5 stated he would check the clinical record for the physician's orders. At the same time, the Medication Administration Record (MAR) was reviewed with LVN 5 for oxygen saturation (a measurement, using a special device, of how much oxygen is being carried by the blood as a percentage of the maximum it could carry) monitoring, none was found. A review of the Licensed Nurses Notes indicated documentation from December 3, 2012, of the resident receiving oxygen at 2 liters per minute. A review of the facility's policy and procedure titled, "Oxygen Administration", dated March 2004 indicated the purpose of the procedure is to provide guidelines for safe oxygen administration: 1. Verify there are physician's orders, and review the facility's protocol. 2. Review the resident's care plan to assess for any special need for the resident. Assessment: Before administering oxygen and	F 328	**Monitoring of Corrective Action and Quality Assurance** DON and DSD will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	

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	055527	A. BUILDING _____ B. WING _____	12/10/2012

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F 328	Continued From page 22 while the resident is receiving oxygen therapy assess for signs and symptoms of cyanosis (blue tone to skin and mucous membranes), hypoxia, oxygen toxicity, lung sounds, vital signs, oxygen saturation, and other laboratory results, if applicable. After completing the oxygen set up the following information should be recorded in the resident's medical record: date, time, name and title of staff, rate of the oxygen flow, route and rational, the frequency and duration of the treatment.	F 328		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage properly. The failure to properly dispose of garbage has a potential for harborage and feeding of pests. Findings: On December 3 -5, 2012, during the survey, there was a large trash bin located in the parking lot used by visitors and staff that was full of trash and furniture items. There was trash observed on the ground. The trash items included food bags and other unknown item inside yellow plastic bags located near the large trash. On December 5, 2012 at 10:30 a.m., during an interview with the maintenance supervisor, he stated the large trash bin would be removed	F 372	**F372 483.35 (i)(3) DISPOSE GARBAGE & REFUSE PROPERLY** **Corrective Action for Affected Area/s** The trash bin was removed and the surrounding area was cleaned immediately on December 6, 2012. **Procedure for Identifying Potentially Affected Areas and Corrective Action** Maintenance Supervisor and the Administrative Assistant conducted an environmental inspection of the facility grounds to identify any potentially affected areas. No concern was identified. **Measures Adopted to Prevent Recurrence** Administrator had a one-on-one in-service with the Maintenance Supervisor on 12/6/2012 regarding proper garbage disposal. Maintenance Supervisor also discussed deficiency noted with the maintenance staff on 12/6/2012 to promote awareness of the regulation, to emphasize the importance of maintaining a safe and clean environment, and to encourage reporting of any identified concern.	1/18/2013

Maintenance Staff will continue to conduct their daily environmental rounds and follow their scheduled grounds maintenance schedule to ensure that the protocol on garbage disposal is consistently followed.

Monitoring of Corrective Action and Quality Assurance

Maintenance Supervisor and Administrative Assistant will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.

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F 372	Continued From page 23 tomorrow, December 6, 2012. He also stated he would have the parking lot cleaned.	F 372		
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure the telephone/verbal orders were signed off by the responsible physician within five days as indicated in the facility's policy for two of 17 sampled residents (9 & 10) and 12 randomly selected residents (RS 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, & 29). Failure of the facility to ensure the physician sign off their orders, could lead to an unsafe practice with potential risk for increased medical errors. Findings: a. On December 5, 2012, a review of Resident 9's clinical record (Face Sheet) indicated the resident was admitted to the facility on November 24, 2011. Resident 9's diagnoses included history of distal femur fracture (broken thigh bone), and dementia ((is a loss of brain function that affects	F 386	**F386 483.40 (b) PHYSICIAN VISITS – REVIEW CARE/NOTES/ORDERS** **Corrective Action for Affected Residents** All physician orders that were identified in this deficiency have already been signed by the physicians as of 1/18/2012. **Procedure for Identifying Potentially Affected Residents and Corrective Action** On-going/daily audit of current clinical records are being conducted by Medical Records staff to ensure that all physician's orders are signed within 5 days. **Measures Adopted to Prevent Recurrence** All telephone orders are now being faxed daily to the physicians' offices for signatures. Signed copies are faxed back to the facilities and filed in the clinical records. Follow-up audit is made daily and copies of telephone orders that remain unsigned are physically delivered to the physicians' offices several times a week to ensure that physician orders are signed within 5 days from the date the telephone order was made. Daily telephone order audit will continue [illegible] checked by the QA Nurse	1/18/2013

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F 386	Continued From page 24 memory, thinking, language, judgment, and behavior), A review of Resident 9's Physician and Telephone Orders dated October 19, 2012, and November 16, 2012, indicated the physician's signature was left blank for at least 47 days. b. On December 5, 2012, a review of Resident 10's clinical record (Face Sheet) indicated the resident was admitted to the facility on February 3, 2011. Resident 10's diagnoses included seizure disorder, encephalopathy (disorder or disease of the brain), dysphagia (difficulty swallowing), and acute kidney failure. A review of Resident 10's Physician and Telephone Orders dated September 29, 2012, and October 14, 2012, indicated the physician's signature was left blank for 66 days. c. On December 5, 2012, a review of RS 18's clinical record (Face Sheet) indicated the resident was admitted to the facility on August 16, 2012. RS 18's diagnoses included chronic pain syndrome, muscle weakness, and dementia. A review of RS 18's Initial Physician's Order dated August 16, 2012, indicated physician's signature was left blank for 110 days. d. On December 5, 2012, a review of RS 19's clinical record (Face Sheet) indicated the resident was admitted to the facility on March 28, 2012. RS 19's diagnoses included seizure disorder, depression, and dementia. A review of RS 19's Physician and Telephone	F 386	Telephone orders that are not signed within 4 days will be reported to the Administrator for immediate intervention. Administrator gave an in-service to all medical records staff on 12/11/2012 regarding the policy and procedure of ensuring that telephone orders are signed off by the physician within 5 days. On 12/11/2012, the DON also gave an in-service to the licensed nurses regarding this regulation. **Monitoring of Corrective Action and Quality Assurance** Medical Records Supervisor will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	

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F 386	Continued From page 25 Orders dated from November 26, 2012, through November 29, 2012, indicated the physician's signature was left blank for at least 69 days. e. On December 5, 2012, a review of RS 20's clinical record (Face Sheet) indicated the resident was admitted to the facility on March 25, 2011. RS 20's diagnoses included high blood pressure, muscle weakness, and high cholesterol. A review of RS 20's initial Physician's Orders dated November 21, 2012, indicated the physician's signature was left blank for 14 days. f. On December 5, 2012, a review of RS 21's clinical record (Face Sheet) indicated the resident was admitted to the facility on July 30, 2009. RS 21's diagnoses included high blood pressure and anemia (low red blood cells). A review of RS 21's Physician and Telephone Orders dated from November 4, 2012, to November 14, 2012, indicated the physician's signature was left blank for at least 31 days. g. On December 5, 2012, a review of RS 22's clinical record (Face Sheet) indicated the resident was admitted to the facility on May 10, 2011. RS 22's diagnoses included seizure disorder, high blood pressure, and high cholesterol. A review of RS 22's Physician Orders for September 2012 indicated the physician's signature was left blank for 95 days. h. On December 5, 2012, a review of RS 23's clinical record (Face Sheet) indicated the resident was admitted to the facility on December 29,	F 386		

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F 386	Continued From page 26	F 386		

2008. RS 23's diagnoses included anxiety disorder, osteoarthritis, and hearing loss.

A review of RS 23's Physician and Telephone Orders dated November 29, 2012, indicated the physician's signature was left blank for six days.

i. On December 5, 2012, a review of RS 24's clinical record (Face Sheet) indicated the resident was admitted to the facility on April 24, 2012. RS 24's diagnoses included Parkinson's disorder (disease of the brain that leads to shaking [tremors] and difficulty with walking, movement, and coordination) and high blood pressure.

A review of RS 24's Physician and Telephone Orders dated November 29, 2012, indicated the physician's signature was left blank for six days.

j. On December 5, 2012, a review of RS 25's clinical record (Face Sheet) indicated the resident was admitted to the facility on November 19, 2012. RS 25's diagnoses included urinary tract infection, depression, and dementia.

A review of RS 25's Physician and Telephone Orders dated November 29, 2012, through November 30, 2012, indicated the physician's signature was left for at least 6 days.

k. On December 5, 2012, a review of RS 26's clinical record (Face Sheet) indicated the resident was admitted to the facility on March 9, 2006. Resident 26's diagnoses included anemia, and schizophrenia (mental disorder marked by severely impaired thinking, emotions, and behaviors).

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F 386	Continued From page 27 A review of RS 26's Physician's Orders dated month October 2012 and November 2012, the physician's signature was left blank for at least 66 days. l. On December 5, 2012, a review of RS 27's clinical record (Face Sheet) indicated the resident was admitted to the facility on August 24, 2012. RS 27's diagnoses included heart disease and lung cancer. A review of RS 27's Physician's Orders dated November 4, 2012 through November 16, 2012, indicated the physician's signature was left blank for at least 31 days. m. On December 5, 2012, a review of RS 28's clinical record (Face Sheet) indicated the resident was admitted to the facility on September 28, 2012. RS 28's diagnoses included anemia and schizophrenia. A review of RS 28's Physician's Orders dated November 20, 2012, through November 21, 2012, indicated the physician's signature was left blank for at least 15 days. n. On December 5, 2012, a review of RS 29's clinical record (Face Sheet) indicated the resident was admitted to the facility on July 12, 2012. RS 29's diagnoses included chronic pain syndrome, high blood pressure, and anxiety disorder. A review of RS 29's Physician's Orders dated September 30, 2012, through October 6, 2012, indicated the physician's signature was left blank for at least 66 days.	F 386		

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F 386	Continued From page 28 During an interview on December 10, 2012 at 11:20 a.m., the director of nursing (DON) stated medical record and nursing were responsible in ensuring the physicians sign off their orders. When asked what is the facility's policy and procedure about doctor's orders, the DON stated, "The medical doctor (MD) has five days to sign the orders." An interview with medical record supervisor on December 10, 2012 at 11:30 a.m., she stated, "Medical record personnel make rounds every morning and look at every chart in the facility and put the red tags on the ones that the doctors need to sign and the nurses are supposed to do that too when they have new orders." A review of the facility's undated policy titled, "Physician Medication Orders," indicated all drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The policy also indicated the drug and treatment orders shall be signed by the prescriber within 5 days.	F 386		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	**F425 483.60 (b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES RPH** **Corrective Action for Affected Residents** Resident was immediately placed on 72-hour monitoring for adverse drug reaction. No adverse reaction noted and resident remained in stable condition.	

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F 425	Continued From page 29 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the residents were given medications accurately according to physician's order for one of six residents observed during medication pass (4). Resident 4 was given a double dose of [redacted] (a medication used to treat some psychotic disorders). This deficient practice had the potential to result in adverse side effects. Findings: On December 5, 2012, during an observation of the 5 p.m. medication pass, the licensed vocational nurse (LVN 6)administered one cubic centimeter (cc) [two milligrams per cc] of [redacted], Norco (used to relieve moderate to severe pain) one tablet, calcium 500 milligrams, vitamin D 400 international units, and Colace (stool softener) five cc to Resident 4. A reconciliation of the physician's orders indicated an order dated November 19, 2012, to give [redacted] one milligram (one half cc) twice daily.	F 425	Attending physician and responsible party were notified of the medication error and resident's stable condition on 12/5/2012. **Procedure for Identifying Potentially Affected Residents and Corrective Action** Medication pass observation of licensed nurses by Pharmacy Consultant and DSD will be completed by 1/18/2013. **Measures Adopted to Prevent Recurrence** LVN 6 is no longer in the facility. Pharmacy Consultant conducted a general in-service to all licensed nurses on 12/18/2012 regarding general medication pass guidelines, with emphasis on ensuring that medications are given accurately according to the physician's order. Medication pass observation will continue to be conducted quarterly or as needed by the Pharmacy Consultant and DSD. **Monitoring of Corrective Action and Quality Assurance** DON will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	1/18/2013

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F 425	Continued From page 30 During an interview on December 5, 2012 at 5:45 p.m., LVN 6 stated she misread the label change on the medication bottle.	F 425	**F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Corrective Action for Affected Residents** Resident 8 was immediately placed in contact isolation on 12/6/2012. **Procedure for Identifying Potentially Affected Residents and Corrective Action** Bowel movement records were reviewed and C.N.A.s were interviewed by the Treatment Nurse and DSD to identify residents who has watery, foul-smelling stools and who are potentially infected by C-diff. No other resident was identified. **Measures Taken to Prevent Recurrence** In-service was given by the DON to all licensed nurses on 12/7/2012 regarding facility policy and procedure titled Infection Control Guidelines for all Nursing Procedure, with emphasis on providing immediate precautionary measure in the event of suspected presence of infectious disease such as C-Diff. Bowel movement reports will continue to be submitted to by the C.N.A.s to licensed nurses on a daily basis and discussed in the stand-up meeting for follow-up. All residents who are reported	
F 441 SS=D	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, 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	F 441		1/18/2013

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F 441	Continued From page 31 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's licensed staff failed to practice infection control measures for one of 17 sampled residents (Resident 8), while awaiting test results for Clostridium difficile (C. difficile, a contagious bacterial infection in the stool). This deficient practice had the potential to cause spread of infection. Findings: A review of Resident 8's admission records indicated he was admitted to the facility on November 19, 2012, with diagnoses including small bowel obstruction) and chronic hepatitis C (viral infection affecting the liver). A Minimum Data Set (MDS), a standardized assessment tool, dated November 25, 2012, indicated the resident understood others, and was understood by others. The resident required extensive assistance from staff with dressing, bathing and personal hygiene. A review of the physician's orders, dated December 5, 2012 at 9:10 a.m., indicated to obtain laboratory tests for the detection of C. difficile titer. An interview on December 6, 2012 at 3 p.m., the registered nurse (RN 2) stated she had obtained	F 441	be monitored and those suspected to have C-diff will be placed on precautionary measures (e.g., nursing staff to wear isolation gown during provision of care) until presence of infection or lack thereof is confirmed. **Monitoring of Corrective Action and Quality Assurance** DON will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	

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F 441	Continued From page 32 orders from the physician for laboratory tests due to the resident's complaint of loose stools and was waiting for the results. RN 2 had no comment why there were no precautionary measures observed such as wearing isolation gown during provision of care to the resident while waiting for the laboratory results. On December 6, 2012 at 4:15 p.m., at Nurses Station 1, the licensed vocational nurse (LVN 8) stated he was contacting the physician of the positive laboratory results for C. difficile for Resident 8. When interviewed, the director of nursing gave no comment if the resident was to be placed on contact isolation while awaiting the laboratory results. A review of the facility's policy and procedure (P&P) titled, Infection Control Guidelines for all Nursing Procedures, dated December 2007 indicated standard precautions would be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. In addition to these general guidelines, refer to procedures for any specific infection control precautions that may be warranted.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 502	**F502 483.75 ADMINISTRATION** **Corrective Action for Affected Residents** Resident 11's attending physician was notified and ordered STAT CBC and BMP. Resident continued to refuse lab. Review of the resident's most recent lab results (August 2012) indicated that CBC and BMP are all within normal limits. MD was notified with no further order	

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F 502	Continued From page 33 failed to ensure one of 17 sampled residents (11) laboratory tests were drawn in accordance to the physician's order. There was no documented evidence the lab tests were drawn for the month of February 2012 when it was ordered and for the month of May 2012. This deficient practice had the potential to cause the physician the inability to monitor and promptly address any lab abnormalities for Resident 11. Findings: A review of the Physician's Orders dated February 2, 2012, indicated an order for blood draw for complete blood count (CBC) and basic metabolic panel (BMP, blood test to evaluate current status of the kidneys as well as electrolyte and acid/base balance and level of blood glucose or sugar) to be done every three months. On December 7, 2012, a review of Resident 11's clinical record (Face Sheet) indicated the resident was admitted to the facility on July 7, 2011. Resident 11's diagnoses included paranoid [redacted] (mental illness characterized by delusions), high blood pressure, and muscle weakness. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated April 4, 2012, indicated Resident 11 had the ability to understand others and made self-understood. According to the MDS, the resident needed limited assistance from staff with her activities of daily living (ADLs), such as, dressing, walking, and toilet use. During an interview on December 7, 2012, at 2:35	F 502	**Procedure for Identifying Potentially Affected Residents and Corrective Action** All lab orders for the month of December as well as those with orders for routine lab works were reviewed by Medical Records to ensure that all scheduled lab orders are logged in the facility's lab binder under the month/date that the labs are ordered to be drawn and are entered into the laboratory computer system. No other concern was reported. **Measures Taken to Prevent Recurrence** In-service was given by the DON on 12/11/2012 to licensed nurses and medical records staff regarding ensuring that lab works are done as ordered. Medical records will continue their audit of laboratory orders to ensure that lab orders are done as scheduled and that results are obtained/communicated to MD/and filed and documented in the clinical records. QA Nurse will review lab binders daily. In addition, Medical Records supervisor will perform a monthly reconciliation of the facility list with laboratory list of routine lab work. Lab requisition forms for these routine labs will be filed in the facility's lab binder under the respective month/date that the labs are ordered/scheduled to be drawn.	1/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. BUILDING _____ B. WING _____	12/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS PALOS CONVALESCENT HOSP	1439 WEST 6TH STREET SAN PEDRO, CA 90732

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F 502	Continued From page 34 p.m. the license vocational nurse (LVN 1) supervisor stated, "I cannot find the blood test results for the months of February and May. We can call the laboratory services to confirm if it was done or not." When the registered nurse (RN) supervisor was asked what happens if a resident refuse to have his/her blood drawn, she responded, "The nurse has to document in the license nurses notes to indicate that and to notify the primary physician." When asked if she could find any documentation of Resident 11 refusing her blood draws on those months, she stated, "No." During a telephone interview on December 7, 2012 at 2:50 p.m., the customer service laboratory representative stated there were no labs drawn in the months of February and May 2012 for Resident 11. A review of the facility's undated policy titled, "Lab Protocol-Day 1", indicated charge nurse receiving the order will carry out the order and prepare lab request and will obtain specimen.	F 502	**Monitoring of Corrective Action and Quality Assurance** DON will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	
F 514 SS=D	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	F 514	**F514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** **Corrective Action for Affected Residents** As stated in the deficiency, Resident 15 has already been discharged from the facility on November 21, 2012. No concern about belongings was received from Resident 15 since he left the facility.	

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F 514	Continued From page 35 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's staff failed to ensure one of 17 sampled residents (Resident 15) closed record inventory list for personal belongings was signed by the resident or the responsible party, on admission and upon discharge from the facility. A potential accurate and complete information will not be attained and a potential for fraud. Findings: A review of Resident 15's clinical records indicated he was admitted to the facility on October 25, 2012, and was discharged to his home on November 21, 2012. A review of the Resident Belongings List, dated November 21, 2012, did not have the resident's or the resident's responsible party's signature for inventory of personal belongings on admission to the facility or upon discharge from the facility. An interview with social services designee on December 10, 2012 at 12 p.m., she stated the facility's Post Discharge Note, dated November 21, 2012, indicated personal belongings were released to Resident 15. However, the personal items were not listed and could not be verified. A review of the facility's policy and procedure titled, Personal Clothing Inventory, dated April 2006, indicated the resident's clothing and	F 514	**Procedure for Identifying Potentially Affected Residents and Corrective Action** On or before January 18, 2013, Medical Records and Social Services Designee will complete a chart audit of all current residents to ensure that inventory lists are signed by the resident/responsible party. **Measures Taken to Prevent Recurrence** Administrator re-educated the medical records and Social Services staff on 12/11/2012 regarding the facility policy and procedure titled Personal Clothing Inventory. DON gave an in-service to all licensed nurses regarding ensuring that the belongings list is signed on admission and on discharge. QA Nurse and medical records will continue to review admission charts and closed records and will give special attention to resident's or responsible party's signature on the belongings list. **Monitoring of Corrective Action and Quality Assurance** Medical Records Supervisor will provide a summary trend analysis of the findings to the Administrator and Quality Assurance and Process Improvement Committee for further evaluation and recommendations.	1/18/2013

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F 514	Continued From page 36 personal effects will be inventoried upon the resident's admission to the facility, and documented on the inventory lists. Individual's receiving the resident's personal effects will be required to sign the release for such items.	F 514		