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

PRINTED: 01/12/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056410	A. BUILDING _____ B. WING _____	11/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3529 WALNUT AVENUE CARMICHAEL, CA 95608

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an annual Federal Recertification survey. Representing the Department of Public Health: HFEN, 29917 / 1958 HFEN, 2860 / 32481 HFEN, 3018 / 36586 HFEN, 2569 / 31321 HFEN, 38177 Pharmaceutical Consultant, 16276 The facility census was 107 with 22 sampled residents.	F 000	Preparation and/or execution of this Plan of Correction do not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the 'Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483." F-246	
F 246 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and resident review the facility failed to provide a means of communication for 2 of 22 sampled Residents, (Resident 1 and Resident 7). Both Residents were non-English speaking residents. This failure prevented the residents from communicating to the staff and had the potential of the facility not meeting their needs.	F 246	1. Resident 1 has a picture communication in his native language at his bedside that was provided by the activity department on 11/3/16. A care conference was held with the resident daughter and son in law on 11/15/16, to address and inform them about his communication book and exercise program amongst other items. Resident 7 has a picture communication book in her native language provided by the activity department on 11/8/16. A telephone conference was held with resident 7 DPOA to discuss the most effective means of communication due to her dementia/hygiene and meals on 11/28/16. Care plan was updated to reflect items discussed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RN — (X6) DATE: 1-19-17

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

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F 246	Continued From page 1 Findings: 1. Resident 1, who is non-English speaking, was admitted to the facility on 7/2014 with Pneumonia (Primary diagnosis) per medical record. In an interview and an observation with the Certified Nurse Assistant (CNA 4) on 11/2/16 at 12:20 p.m., CNA 4 said, referring to Resident 1, "I don't know anyone in the facility that speaks [his native language]." CNA 4 also confirmed that there was no communication book (a book for non-English speaking Residents for translation with pictures) at Resident 1's bedside. In an interview with Licensed Nurse (LN) 4 on 11/2/16 at 12:41 p.m. she stated, "If I need to communicate with him I would look at our policy." During an interview on 11/3/16 at 9:10 a.m. the Assistant Director of Nursing (ADON) 2 was asked to arrange an interview with Resident 1 (a non-English speaking Resident). The ADON 2 called the family requesting them to translate for Resident 1. The family was not available to assist with this interview. The ADON 2 called the Director of Nursing (DON) and she advised her to call the family again for assistance with translating for Resident 1. The family was at work. In a concurrent interview with the DON, she said we have a phone number for translators but we have not used this translation process yet. During a Resident interview with Resident 1 and his Representative (daughter) on 11/3/16 at 9:15 a.m., he said when his CNA was changed he had difficulty communicating with them. Resident 1 said he would like to get up in his wheelchair more often and exercise more on the bicycle.	F 246	For current and future residents that have the potential to be affected by this deficient practice the AD updated the communication book for residents that are non English speaking with assistance from family members on 11/28/16. The Director of Staff Development (DSD) in serviced the staff on 11/28/16 through 11/30/16 on means of communication with resident that are non-English speaking. Upon admission and quarterly, the Activity Director (AD) will meet with resident and their responsible party to establish a communication book/or other means of communication to accommodate the resident needs. The communication book will be placed at the resident bedside. The AD and Minimum Data Assessment Nurse (MDS) will create a care plan to address the residents need. The DSD will in-service the staff on the communication books. Each quarter and as needed, the AD will ensure that the resident means of communication is met through a Care conference with Responsible family members	

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F 246	Continued From page 2 Resident 1 and his Representative said they would like for him to have a "communication book" and they had never had anyone offer this to them. In a record review of Resident 1's medical record, Care Plan, dated 9/25/16, under Problem, Category: Communication, it stated "At risk for Altered Communication R/T: Language barrier Speaks [native language], may miss part or all of message." Under "Approach" it stated, "...ask resident to repeat what has been said to confirm the message was understood." And, "Face the resident when speaking." 2. Review of the document titled History and Physical indicated Resident 7 was non English speaking. During an observation on 11/2/16 at 12:45 p.m., Resident 7 was in the dining room for lunch. Resident 7 was seated in her wheel chair and sitting alone at the table. Certified Nursing Assistant (CNA) 2 came to table with Resident 7's lunch. CNA 2 made numerous attempts to encourage Resident 7 to eat. Resident 7 was observed pushing CNA 2 away while speaking in her native language. CNA 2 spoke to Resident 7 in English. In a concurrent interview, CNA 2 stated she did not know what language Resident 7 spoke. She further stated she did not know if Resident 7 had a communication board. During the interview, a surveyor, who knew some words in Resident 7's native language, approached the table and asked the resident if she was hungry in her native language. Resident 7 immediately lit up, smiled and responded in her native language, and freely	F 246	/resident and availability of communication books at bedside. The AD will report any non compliance issues to the quality assurance committee for recommendations as needed.	

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F 246	Continued From page 3 allowed CNA 2 to feed her. On 11/3/16 at 10:45 a.m., Resident 7 was observed sitting in front of the nursing station in her wheelchair, as a staff member unsuccessfully attempted to have her drink water from a glass. After several failed attempts, the surveyor who knew some words in her native tongue, approached the resident and asked her in her native language if she was thirsty. The resident's face lit up, and she began to drink from the glass until consuming the whole 6 ounces. In a telephone interview on 11/4/16 at 3:00 p.m., Resident 7's younger daughter stated that her mother used to speak English, but after both falls this year, she seemed to only remember her native language except to say "Thank-You." She further stated her mom answered short questions appropriately in her own language, but longer conversations became jumbled and confused. In an interview on 11/8/16 at 11 a.m., Resident 7's oldest daughter stated her mother did not speak much English anymore. She expressed concern about her mother's care regarding eating and hygiene. She further stated her mother "doesn't always eat well." Record review of the document titled Resident Progress notes for Resident 7 indicated the following: A. 10/03/16 at 12:10 p.m., "She has communication book at her bedside and uses gestures to communicate needs..." B. 10/08/16 at 1:13 a.m., "Alert with confusion..., speaks [native language] with few words in	F 246		

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F 246	Continued From page 4 English...". C. 10/13/16 at 9:40 a.m., "Quarterly assessment... Communication: Res [resident] has clear speech and speak and understand [native language]." D. 10/22/16 at 15:25 (3:25 p.m.), "Resident is alert and verbally responsive with confusion, speak few English words at times, mostly in [native language]." Review of the document titled Resident Progress notes dated 10/21/16 at 10:52 a.m. - IDT (Inter Disciplinary Team) Wt (weight) Meeting Indicated Resident 7 had a 5 pound weight loss in one week with an average meal intake of 50%. "Goal to deter further [weight] loss from occurring." Review of the document titled Care Plan, dated 10/12/16 under Problem, indicated "Resident does not speak in the dominant language of the facility...Resident will establish a reliable means of communication as evidenced by: happy facial expressions...Encourage resident to use gestures, basic English when expressing self." Review of the document titled Care Plan dated 9/28/16 indicated, "Return to Community Referral weight loss...weight to remain stable." Approaches included "Encourage food/ supplements/ fluids as ordered, offer substitutes if resident has problem w/ [with] foods being served..." The facility's policy titled, "Communication, Translation and/or Interpretation of Facility Services" revised June 2013 indicated, "This facility's language access program will ensure	F 246		

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F 246	Continued From page 5 that individuals with Limited English Proficiency (LEP) shall have meaningful access to information and services provided by the facility...The facility notifies non-English speaking residents of the availability of Residents' Rights in their language...Competent translation of vital information will be provided in a timely manner and at no cost to the resident through the following means...A staff member who is trained and competent in the skill of interpreting...Contracted interpreter service...Voluntary community interpreters who are trained and competent in the skill of interpreting...Telephone interpretation service...It is understood that providing meaningful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral, written or picture communication or interpretation services therefore include interpretation from the LEP resident's primary language back to English." 483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a comprehensive assessment for 1 of 22 sampled Residents (Resident 1) within the required time frame. This failure had the potential for unnoticed change in status for Resident 1.	F 246	F-275 The facility had self identified the missed annual MDS assessment and documented on the Quality assurance minutes dated 4/20/16. For current and future residents that have the potential to be affected by this deficient practice, on 11/28/16 & 11/29/16, the MDS coordinator generated a MDS due report and manually checked each resident record to ensure that the MDS was completed accordingly. The Director of Nursing (DON) in serviced the MDS coordinators on double checking missed assessments by means of generating the MDS due report and manually checking to ensure the comprehensive assessment is completed in the required time frame. Each month, the MDS coordinator will generate the MDS due report and manually compare it with the completed monthly assessment to verify all due assessments are completed as required. Any discrepancies will be corrected accordingly. The completed audit/report will be given to the DON for verification.	
F 275 SS=D		F 275		

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F 275	Continued From page 6 Findings: According to the medical record, Resident 1 was admitted to the facility with Pneumonia as his primary diagnosis. Review of Resident 1's Minimum Data Set (MDS - an assessment tool) there was no annual comprehensive assessment MDS conducted for Resident 1, for the year 2015. In a concurrent interview with the MDS Nurse, she confirmed that it was not done and said, there was a glitch in the system. In an interview with the Director of Nurses (DON) on 11/2/16 at 5:30 p.m. she too confirmed, there was a "missed" annual comprehensive MDS for 2015 for Resident 1. In a review of the facility policy titled, "MDS Completion and submission Timeframe's" Revised on October 2010, "The Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted to ...in accordance with current federal and state guidelines...The following timeframe will be observed by this facility: Assessment Type Annual (Comprehensive) Submission of MDS records ...will be by electronic means. A hard copy of each record submitted will be maintained in the resident's clinical record for a period of fifteen (15) months from the date such data was submitted."	F 275	Monthly times 3 months then quarterly thereafter, the DON will perform 5 random MDS audits to ensure that the MDS are completed as required. The MDS coordinator will report any non compliance issues to the quality assurance committee for recommendations as needed. **F-279** Resident 18 reported acute pain of 8/10 on 11/3/16 and interventions were implemented to include skilled therapy for modalities. The care plan was updated to reflect these interventions. Resident 5 next lab due is 11/28/16, to evaluate resident blood levels in relation to her anemia. Resident 5 care plans were updated on 11/5/16 to reflect her diagnosis. Resident 9 care plans were in place on 11/4/16 for use of psychotherapeutic medications. She was transferred to the acute on 11/4/16 and returned to facility on 11/7/16. New care plans were then developed to address use of psychoactive medications.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 7 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 §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, staff interview, and document review the facility failed to ensure that care plans had specific and measurable components to be monitored in order to achieve the intended goals of the care plans for 3 of the 22 sampled residents (Resident 5, Resident 9, and Resident 18). This Failure had the potential to compromise the quality of care for residents. Findings: 1. Resident 18 is bed bound, has had nerve pain (neuropathy) and other pain issues since 2012. In an interview on 11/2/16 at 10:50 a.m., Resident	F 279	For current and future residents that have the potential to be affected by this deficient practice; a) The nursing department managers interviewed and updated the resident pain care plans on 11/28/16 through 11/30/16. Licensed nurses will assess resident pain on an ongoing basis and update care plans as needed. b) During the November medication monthly regimen review- 11/28 through 12/2/16, the pharmacist will review medications and make recommendations for labs and monthly thereafter c) The MDS coordinator will update the residents' care plans to reflect current diagnosis with a completion date of 12/1/16. d) The Social Services Director (SSD) will review residents on psychotropic medications and ensure each has a care plan that reflects their care/use of medications through 12/2/16. The DON in serviced the licensed nurses on assessing pain and care planning on 11/28/16 and 11/29/16. Each quarter, the MDS nurse will assess and update the pain care plan as needed.	

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F 279	Continued From page 8 18 stated that most of the time, she had a pain level of 8/10, on a pain scale of zero (no pain at all) to ten (worst pain). When Resident 18 was asked if she told facility staff about her pain, she said she has told the doctor about the pain and the doctor said, "there is nothing they can do about it." When asked if her pain ever went down to a zero, Resident 18 said, "No" and indicated that she was always in pain and that she "can't walk." A review of the Minimum Data Set (MDS), a tool for assessing residents physical and psychosocial well-being, assessment for Resident 18 on 8/19/16 noted, "No Complaints of Pain" was documented for Resident 18. The MDS assessment also had a 'Yes' checked for the question regarding, "Received non-medication intervention?" In an interview with the Minimum Data Set Assistant (MDSA) on 11/3/16 at approximately 11:15 a.m., questions were asked about the MDS pain assessment for Resident 18. When asked about Resident 18's non-medication intervention for pain, she stated, "the resident has a cell phone, a t.v., and family..." A review of the care plan on 11/3/16 at approximately 4:30 p.m. showed that the care plan was written on 11/23/12 and the last reviewed/revised date was on 8/19/16. The plan had seven entries, and all of them were dated 10/24/12. The Medical Records Director (MRD), in an interview on 11/4/16 at approximately 11:00 a.m., confirmed that the care plan for Resident 18 had not been updated recently. The goal for managing Resident 18's pain in the	F 279	Upon admit and quarterly the MDS coordinators will ensure that the resident diagnosis listed on the residents face sheet is also care planned accordingly. Each quarter the SSD will update the care plan for residents on psycho tropics to ensure it meets residents' needs. The Medical Record Director (MRD) will perform monthly audits times 3 months then quarterly thereafter on completed MDS' and ensure that care plans have been updated accordingly. The audit is then handed to the DON for follow up as needed. The MDS nurse will report any non compliance issues to the quality assurance committee for recommendations as needed	

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F 279	Continued From page 9 care plan indicated: "Resident will verbalize reduction of pain." The facility's policy, Pain Assessment and Management, revised March 2015, included, "Review the resident's treatment record or recent nurses' notes to identify any situations or interventions where an increase in the resident's pain may be anticipated..." and "The pain management interventions shall be consistent with the resident's goals for treatment." In addition, the policy included, "Effectively recognizing the presence of pain... Monitoring for the effectiveness of interventions; and Modifying approaches as necessary." 2. Review of Resident 5's medication administration record (MAR), noted Resident 5 had been placed on ferrous sulfate (A medication given to treat decreased iron in the blood) 325 mg. (unit of measure) by mouth once per day for anemia (a low level of red blood cells), since 3/31/16. Further review of Resident 5's records showed no current blood level to evaluate Resident 5's anemia. The record for Resident 5 had no anemia listed on the diagnosis list, though Resident 5 was being treated for anemia. Blood level for hemoglobin and hematocrit (H/H - the ratio of red blood cells to the total volume of blood) were checked on 4/1/16 and 8/1/16 but there was no care plan for anemia. On 11/4/16 at 4:30 p.m., the Medical Records Director (MRD) was asked about development of	F 279		

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F 279	Continued From page 10 care plans, she stated that the care plans were developed when the Minimum Data Sheet (A resident assessment tool) is completed for any new diagnosis as indicated. MRD was asked for all care plans for Resident 6. Review of the care plans provided for Resident 6 showed no care plan for anemia. During an interview with the DON and MRD on 11/4/16 at 4:63 p.m., they confirmed the absence of a written care plan addressing the anemia, in both paper and electronic medical records for Resident 6. 3. Resident 9 was admitted to the facility on February 2016 with Bipolar disorder, depression and multiple stomach and liver disorders. Review of the document titled Physician Order Report dated 10/8/16 - 11/2/16, indicated Resident 9 was on three psychotherapeutic medications. During a review of the documents titled Care Plans on 11/4/16, there was no care plan found for Resident 9 for care of a resident with psychiatric disorders or care plan pertaining to the care of a resident on psychotherapeutic medications. In a interview on 11/8/16 at 10:15 a.m., the Director of Nursing confirmed the care plans were not done.	F 279		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 11 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to properly maintain the sidewalk of the courtyard, potentially used by the 105 of 107 residents in the facility, in a safe condition when parts of the sidewalk was elevated causing a trip hazard. This failure had the potential to cause injury. Findings: During the completion of environmental tour on 11/3/16 at 8:00 a.m. The resident courtyard was observed with the Maintenance Supervisor (MS). There were multiple areas of the sidewalk that were uneven, and some parts were elevated 1 to 3 inches. In a concurrent interview the MS stated the uneven areas were caused by the surface tree roots damaging the sidewalks and the building. He further stated he has had to help some residents with their wheelchairs when they come outside and cannot roll freely over the elevated areas. The MS stated the facility is "aware of the problem and has plans to redo the entire courtyard and possibly replace the trees." He acknowledged the uneven pavement was a trip hazard and in need of repair.	F 323	F 323 The uneven areas in the courtyard were grinded by the maintenance department staff. On 11/30/16 through 12/2/16, the facility maintenance supervisor grinded down the un-even surfaces in the patio area. The facility administrator in serviced the maintenance supervisor on performing monthly environmental rounds and making necessary repairs on 11/30/16. The Facility administrator and the maintenance supervisor will perform environmental rounds monthly times 3 months then quarterly thereafter to ensure that any uneven surfaces in the facility grounds are repaired as needed. The maintenance supervisor will report any non compliance issues to the quality assurance committee for recommendations as needed.	
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329	F 329 1. Resident 18 pain medication regimen was reviewed by the physician on 11/4/16.	

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F 329 SS=E	Continued From page 12 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 antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review the facility failed to ensure that four of 22 sampled residents were free from unnecessary medications as defined by inadequate monitoring (Residents 5, 6, 17 and 18.) This failure had the potential to put residents at increased risk for developing adverse consequences, therapy failure and negative	F 329	2. Resident 17s hypnotic order was discontinued on 10/19/16. 3a) provider reviewed the use of Lopid on 11/29/16 for resident 6. Orders for Lipid panel were placed. 3b) provider reviewed the use of ferrous sulfate on 11/29/16 .for resident 6. Orders placed Hemoglobin/Hematocrit. 3c) lab result for TSH dated 1/6/16 was reviewed by the provider. New labs were ordered. (3 attempts were made on 10/29, 10-30, 11/1, and resident refused to have labs drawn. Care plan was updated to reflect refuses). 4) For resident 5, provider reviewed use of Lipitor on 11/29/16 and labs were ordered. The consultant pharmacist will review resident drug regimen for the above residents and other current residents and make necessary recommendations to the providers 11/28/16 through 12/2/16. Recommendations made will be given to the DON who will then follow up with the providers for needed orders. Monthly, the consultant pharmacist will review the residents' medication drug regimen and make necessary recommendations.	

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F 329	Continued From page 13 outcome. Findings: 1. On 11/2/16 at 8:30 a.m. during observation of the medication administration, Licensed Nurse 6 (LN 6) gave Resident 18 two medications for pain, gabapentin (known as Neurontin) and tramadol (known as Ultram). Resident 18 is bed bound and has had nerve pain (neuropathy) and other pain issues since 2012. In an interview on 11/2/16 at 10:50 a.m., Resident 18 stated that most of the time she had a pain level of 8/10, on a pain scale of zero (no pain at all) to ten (worst pain). When the Resident 18 was asked if she told facility staff about her pain, she said she has told the doctor about the pain and the doctor said, "there is nothing they can do about it." When asked if her pain ever went down to a zero, Resident 18 said, "No" and indicated that she was always in pain and that she "can't walk." A review of Resident 18's medical administration record (MAR) on 11/2/16 showed that she was receiving scheduled doses of tramadol 50 milligrams (mg) three times a day and gabapentin 600 mg three times a day. In addition, Resident 18 received Tylenol 650 mg every four hours as needed for pain. On 11/2/16, further review of the MAR during the four months prior (July, August, September and October of 2016) showed documentation of zero on daily basis on every shift, with a few exceptions. On 11/2/16 at 10:50 a.m., Licensed Nurse (LN6) and Licensed Nurse 7 (LN7) stated that pain assessment is documented at the end of the shift.	F 329	Monthly times 3 months then quarterly thereafter, the DON will perform 10 random chart audits to ensure residents' medication regimen is reviewed to include recommendations for needed labs or review of medications. The DON in serviced the LN on 11/28/16 & 11/30/16 regarding a) Monitoring and documentation of residents' pain levels. b). Monitoring and documenting therapeutic effects of PRN medications administered During their shift, the licensed nurses will monitor resident pain level and therapeutic effects of other PRN medications administered and document accordingly. The Medical record department will audit the Electronic Medication Administration Record (EMAR) weekly times 4 weeks and monthly thereafter to ensure that medications administered that require monitoring are adequately monitored and documented. The MRD will hand the audits to the DON for follow up as needed	

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F 329	Continued From page 14 LN 6 added that the pain score may be modified after it is entered into the system. On 11/3/16 at 4:10 p.m., Resident 18 was asked about her pain level and she indicated that it was an 8 out of 10. Resident 18 stated her pain level was 8/10 on three different occasions on 11/2/16 and 11/3/16. The pain monitoring for Resident 18 was inaccurate because the medical record showed documentation of zero pain level even on days the resident was given Tylenol for pain. 2. On 11/2/16 at 12:12 p.m., expired or discontinued controlled substances stored at the DON's office were evaluated. Temazepam (a medication given for inability to sleep) for sample Resident 17 was randomly selected for evaluation. Temazepam 15 mg was ordered to be giving at bedtime for aiding sleep, and may repeat times one as needed. Review of the accountability record (also known as controlled substance record) for temazepam showed documentation that three different doses were signed out: on 9/5/16, 9/6/16, and 9/12/16. Review of the medication administration record (MAR) for Resident 17 showed three out of three times, the assessments were documented as "NE" (Not Effective). There was no documented evidence that a follow-up action was taken to address the lack of effectiveness of the medication administered, such as administering another dose as ordered by the physician. For the dose signed out and administered on 9/21/16, temazepam was given at 9:45 p.m., and the assessment was documented six hours later at 3:39 a.m. There was no clinical justification for lack of timely assessment.	F 329	The DON will report any non compliance issues to the quality assurance committee for recommendations as needed.	

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F 329	Continued From page 15	F 329		

3a) Resident 6 was admitted by facility with diagnoses including, high cholesterol (Cholesterol is a fat-like substance that, at high levels, is deposited on the walls of blood vessels and increase the risk of heart disease.)

Review of Resident 6's MAR's showed a physician order for Lopid (a medication to lower the cholesterol level) 600 mg. (a unit of measure), to be given twice a day since 12/11/14.

The (MAR), for Resident 6 showed that the resident has been on Lopid 600 mg twice a day since 12/11/14. Review of the record showed no cholesterol panel (a blood test to show levels of cholesterol) since 12/11/14.

During an interview with the Director of Nursing (DON) on 11/4/16 at 4:45 p.m., the DON confirmed the absence of Lipid panel for Resident 6 (A lipid panel measures - fats and fatty substances used as a source of energy by your body- in the blood.)

3b) During a review of Resident 6's MAR's, noted resident was prescribed ferrous sulfate (A medication to treat decreased iron in the blood.) 325 mg. (Unit of measure) by mouth once per day for anemia. Anemia is a deficiency of red blood cells or of hemoglobin in the blood. Further review of R 6's records showed the most recent lab to check for improvement for anemia was on 8/18/2015. One of the labs test that check for anemia is H/H: Hemoglobin (oxygen carrying protein) and Hematocrit (the ratio of red blood cells to the total volume of blood.)

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F 329	Continued From page 16 During an interview with the DON, and the MRD on 11/4/16 at 4:53 p.m., they confirmed that there was no other levels or more current ones after 8/18/2015. 3c) During further review of the records for Resident 6, it was noted that the resident was receiving levothyroxine (medication used to treat low levels of thyroid hormone in the blood) 25 microgram every day since 12/11/14. The most recent Thyroid Stimulating Hormone (TSH) level (A blood test used to evaluate response to thyroid therapy) done was on 1/6/16, and it was elevated. The level was 6.57, and the normal range is 0.34 - 4.82. There was no documented evidence that the facility took any actions regarding the elevated TSH level. Monitoring TSH is used to guide treatment and evaluate effectiveness, however the facility did not use the lab result to guide Resident 6's treatment. During an interview on 11/4/16 at 5:10 p.m., the DON acknowledged absence of action related to the TSH elevated level. 4. Resident 5 was prescribed a medication (atorvastatin) for high cholesterol (Cholesterol is a fat-like substance that, if the level is high, will accumulate in the walls of the blood vessels and may increase the risk of heart disease). Review of Resident 5's medical record showed a physician order from 3/31/16, for atorvastatin (also known as lipitor) 40 mg., to be given every	F 329		

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F 329	Continued From page 17 day at bed time. The Medication Administration Record (MAR), for Resident 5 showed that the resident had been on atorvastatin since admission, 3/31/16. Review of the record showed no cholesterol panel had been done since 3/31/16 to check the resident's levels of cholesterol. During an interview with the Director of Nursing (DON) on 11/4/16 at 4:45 p.m., the DON confirmed the absence of Lipid panel for Resident 5 (A lipid panel measures - fats and fatty substances used as a source of energy by your body.	F 329	F-333 A medication administration error report was completed by the DON and Licensed Nurse 10 on 11/8/16. For current and future residents that have the potential to be affected by this deficient practice, the Medical Record staff completed an audit on 12/2/16 on diabetic residents, to ensure that the residents received the correct dose of insulin that correlates to the MD orders as per the insulin sliding scale. Audits were given to the DON for follow up. The DON in serviced the Licensed Nurses (LN) on 11/28/16 & 11/30/16 regarding the 8 rights of medication administration. Weekly times 4 weeks and monthly thereafter, the MRD will complete audits on diabetic residents. They will ensure that residents who have sliding scale orders received the ordered insulin dose per the MD orders. Competed audits will be handed to the DON for follow up as needed. The MRD will report any non compliance issues to the quality	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the residents were free of any significant medication errors when the wrong dose of insulin was documented on the Medication Administration Record (MAR) for 1 of 22 sampled Residents (Resident 1). This failure had the potential to jeopardize the residents' health and safety. Findings: Resident 1 was admitted to the facility with Pneumonia. In a review of the MAR for 10/15/16 a physicians order indicated, "Humulin R (Regular human insulin) solution; 100 unit/ml: injection, Before Meals for DM (Diabetes). Less than 60 If	F 333		

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F 333	Continued From page 18 alert, Glucagon/Juice recheck 30 min. Hold insulin, if unresponsive call MD. BS (blood sugar) 60-150=0 BS 151-200=2 unit BS 201-250=4 BS 251-300=6 unit BS 301-350=8 unit BS 351-400=10 unit BS 401-450=12 unit Notify MD. IF greater than 450=14 units & check in 2 hrs. call MD if still greater than 450. The MAR indicated on 10/15/16 at 7:00 a.m. Licensed Nurse (LN) 10 gave Resident 1 14 units rather than 12 units of Humulin R insulin, when his Blood Sugar reading was 446 mg/dl. In an interview with the Director of Nurses (DON) on 11/4/16 at 1:45 p.m. she stated, "Yes, that is a med error, we filled out a med error form yesterday after I spoke to the nurse." In a subsequent interview with LN 10, she could not be exactly sure if she gave the incorrect dose, or if it was mainly a documentation error.	F 333	assurance committee for recommendations as needed **F-431** 1. For resident 14, the LN that signed for the Norco on the narcotic log completed a medication error report on 11/8/16. 2. Random Resident J was admitted to the facility on 7/19/16 and has been on Percocet. The discontinued controlled drug medication logs stored in the DON office does not have any medications logged for resident J.	
F 431 SS=E	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.	F 431	The MRD performed an audit on 11/29/16 through 12/1/16 to verify that all narcotics signed on the narcotic log book are also documented on the EMAR accordingly. The audit was given to the DON for follow up. The DON in serviced the LN on 11/29/16 & 11/30.16 regarding the 6 rights of medication administration. Weekly times 4 weeks then monthly thereafter, the MRD will perform	

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F 431	Continued From page 19 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 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 medical record and staff interview, the facility failed to ensure accurate accountability of all controlled substances when it failed to detect and identify potential misuse or abuse in a timely manner. Lack of accountability facilitates misuse or abuse of controlled substance, and subsequently places patients at risk for pain and suffering when the medications intended to treat them is not administered or is inaccurately documented. Findings : 1. On 11/2/16 at approximately 11 a.m., the controlled drug record for Norco (a narcotic pain medication) for Resident 14 was randomly selected for evaluation. The order was written to administer one tablet every four hours as needed	F 431	audits to compare the narcotic log verses the EMAR. The audits will be handed to the DON for follow up as needed. The DON will report any non compliance issues to the quality assurance committee for recommendations as needed.	

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F 431	Continued From page 20 for moderate pain and two tablets every four hours as needed for severe pain. According to the controlled drug record, on 10/22/16 at 8:00 p.m., two tablets of Norco were signed out. However, review of the medication administration record (MAR) showed no documentation that the two tablets were administered. This finding was confirmed in an interview with the Medical Record Director (MRD) on 11/4/16 at 10:50 a.m. The controlled drug record for Resident 14 also showed that on 10/22/16 at 6 p.m., two tablets were signed out. The MAR showed that the medication was administered about an hour before the medication was signed out at 4:41 p.m. Additionally, the controlled drug record also showed that on 10/17/16 at 6 p.m., two tablets were signed out. The MAR showed that the medication was administered at 5:04 p.m., about an hour before the medication was signed out. This finding was confirmed in an interview with the MRD on 11/4/16 at 10:50 a.m., and no justification was provided for the discrepancy in the record. It is not possible to administer medications before obtaining them. This practice of documentation allows for inaccuracies and can lead to medication administration errors. It also facilitates misuse or abuse of controlled substance. It would be impossible to know if the controlled tablets were actually administered or not. 2. On 11/2/16 at 12:12 p.m., expired or discontinued controlled drug substances stored at the DON's office were evaluated. A randomly selected controlled drug record was chosen for Resident J. The controlled drug record for Norco (narcotic pain medication) was evaluated. The	F 431		

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F 431	Continued From page 21 order was written to administer one tablet every four hours as needed for moderate pain and two tablets every four hours as needed for severe pain. The controlled drug record showed that on 10/6/16 at 5:00 a.m., two tablets were signed out and removed from the cart. The MAR showed that the controlled medication was administered at 3:12 a.m., about two hours before the medication was obtained. In addition, the controlled drug record showed that on 10/5/16 at 2:00 a.m., two doses were signed out. The MAR showed that the medication was administered at 1:38 a.m. about a half an hour before the medication was obtained. When the facility's policy on controlled substances was requested, the policy on Controlled Substances, revised December 2012, was given along with a "Controlled Medications" policy from Pacific-West Pharmacy, version 1.0, effective date: June 2016. A review of these policies showed procedures that included, "When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information... Date and time of administration..." There was evidence that the facility failed to follow their written policy when administering controlled substances.	F 431	F-441 1. The ham identified in the refrigerator was disposed off on 11/1/16. The RD inspected the dietary department for any expired food items on 11/8/16. The RD in serviced the dietary staff on proper storage of food and disposition after its expiration date on 11/8/16 & 11/28/16. Weekly the RD will inspect the refrigerator for compliance. The RD will report any non compliance issues to the quality assurance committee for recommendations as needed. 2. The Director of Staff Development (DSD) in serviced the dietary staff on proper hand washing techniques on 11/28/16 through 12/1/16. Weekly times 4 weeks then monthly thereafter, the Dietary supervisor will perform 4 random hand washing skill checks on the dietary staff.	
F 441 SS=E	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	F 441		

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F 441	Continued From page 22 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 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to maintain a proper infection Control Program when:	F 441	Any concerns identified will be forwarded to the DSD for follow up as needed. Each Quarter the DSD will visit the dietary department and perform hand random hand washing skill checks with the dietary staff. The DSD will report any non compliance issues to the quality assurance committee for recommendations as needed. 3. The DS in serviced the staff on proper disposal of garbage in the kitchen on 11/28/16 through 12/1/16. The RD will perform daily rounds times one week, weekly rounds times 4 weeks and monthly thereafter to ensure that the garbage is disposed of accordingly. The RD will report any non compliance issues to the quality assurance committee for recommendations as needed. 4. The Director of Staff Development (DSD) in serviced the house keeping staff on proper hand washing techniques on 11/28/16 through 12/1/16.	

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F 441	Continued From page 23 1. Food was stored in the refrigerator beyond it's expiration date; 2. Proper hand washing was not implemented in the kitchen; 3. Garbage in the kitchen was improperly handled; 4. Proper hand washing was not implemented; and, 5. Medical devices were not properly handled after cleaning. These failures had the potential to affect the safety of all staff and residents, and failed to provide a sanitary and comfortable environment by exposing residents and staff to transmission of possible disease and infection. Findings: 1. During the Initial Tour of the facility's kitchen on 11/1/16 at 8:35 a.m., ham was observed in the walk-in refrigerator with a date of 10/28/16. During a concurrent interview with the Dietary Supervisor (DS), the DS stated that the ham was going to be used for the chef salad. During an interview with the facility's Dietitian on 11/1/16 at 9:10 a.m., the Dietitian responded that the ham should be used three days after the date it was opened, by 10/31/16, it was opened 10/28/16. During a review of the facility document titled, REFRIGERATED STORAGE GUIDE dated, 2015, it stipulated that, ..."Left over cooked meats ... Maximum Refrigeration Time, 3 days." 2. During the same Initial Tour of the facility on	F 441	Weekly times 4 weeks then monthly thereafter, the house keeping supervisor will perform 4 random hand washing skill checks with the housekeeping staff. Any concerns identified will be forwarded to the DSD for follow up as needed. Each Quarter the DSD will perform random hand washing skill checks with the housekeeping staff. The DSD will report any non compliance issues to the quality assurance committee for recommendations as needed 5. The DSD in serviced the staff on proper handling of medical devices after cleaning on 11/28/16 through 11/30/16. Weekly times 4 weeks, the DSD will perform facility rounds and observe for proper cleaning of medical devices. Monthly during the licensed nurses meeting, the LN will be able to demonstrate proper cleaning of medical devices. The DON will report any non compliance issues to the quality assurance committee for recommendations as needed.	

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F 441	Continued From page 24 11/1/16, at 10:40 a.m., observed five of the dietary staff including the Dietitian, use improper hand washing technique. They were observed placing lather first on their hands then quickly rinsing the hands with water. During a concurrent interview with the Dietary Supervisor (DS), when asked what was the acceptable hand washing technique, the DS responded, and acknowledged the lack of proper technique observed with the dietary staff. Shortly after this, improper hand washing technique was observed to continue, the DS called attention to the kitchen staff as to the expected and proper hand washing technique, "Water first, lather and wash for 30 seconds." During review of the facility's policy and procedure titled, "HAND WASHING PROCEDURE, dated, 3/13, it stipulated, ..."Wet hands, and forearms first. Add soap, and rub hands together forming lather, ... for 20 seconds." 3. During the same Initial Tour of the facility on 11/1/16, at 10:35 a.m., the Dietary Aide (DA) was observed placing a leaking plastic bag of garbage on top of a garbage can near the staff's hand washing sink. During a concurrent interview with the DA, when asked the proper way to handle a leaking garbage bag, the DA responded, the reason of placing the plastic garbage bag on top of the garbage can was because there was more garbage to add to bag. Further interview with the DA, on the proper and different way to handle leaking garbage bag, the DA responded, "it should not leak on the floor, and should take it outside to prevent cross contamination." A concurrent interview with the	F 441		

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F 441	Continued From page 25 DS, the DS added that the DA should have asked for help and then add more garbage to the garbage bag to prevent cross contamination. Neither the DS nor the DA mentioned the need to wipe the floor of the dripping substance, or disinfect the top of the garbage can. During an interview with the Director of Staff Development/Infection Preventionist (DSD/IP) on 11/2/16 at 5:15 p.m., the DSD/IP confirmed the same hand washing procedure outlined in the facility's policy and procedure. DSD/IP further added that "All garbage is considered potentially infectious and therefore should be disposed of appropriately. DSD/IP added that another non leaking bag should have been used to prevent leaking on the floor, and the wetness on the floor and the top of garbage can should have been wiped cleaned and disinfected. 4 a) During initial tour on 11/1/16 at 9:09 a.m., a Certified Nursing Assistant 3 (CNA 3) was observed exiting a private resident's room, which had isolation precautions for Clostridium difficile (C. Diff, an infectious intestinal bacteria). Prior to exiting the room, CNA 3 did not wash her hands. CNA 3 proceeded to go to the Utility Room across the hall from the resident's room to wash her hands; this observation was confirmed by an interview with Licensed Nurse 8, on 11/1/16 at 9:15 a.m. The handle on the utility room door had a key code to unlock the door. The CNA 3 pushed the buttons on the keypad with her contaminated hands to unlock the door, opened the door, and entered the room to wash her hands. Using the utility room to wash her hands resulted in a potential infectious site on the door	F 441		

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F 441	Continued From page 26 handle and keypad for subsequent staff. 4 b) On 11/1/16 at 3:24 p.m., Housekeeping Staff 1 and Housekeeping Staff 2 (HS1 and HS2) were seen cleaning room 402 for a resident on isolation precautions with C.Diff. HS2 was standing outside of the room, clenching a roll of garbage bags under her arm, and holding onto garbage bags, a container of bleach wipes and a spray bottle of bleach. When asked to explain her role in cleaning the room, HS2 stated that she was handing cleaning implements to HS1 who was cleaning within room 402, "as he needed them". It was explained that upon handing the spray bottle of bleach, HS1 would use the spray inside of the room and hand the bottle back to HS2. HS2 said that she would take the bottle and using the bleach wipes that she was carrying, would wipe the bottle clean. HS1 was observed in the room cleaning the room and upon exiting, did not wash his hands neither in the resident's room nor outside in the utility room. HS1 was observed pushing the housekeeping cart down the hall with potentially contaminated hands on the handle of the cart. He then continued to take dirty trash bags outside the facility through a public door, touching the handle bar of the door. HS1 stated in an interview on 11/1/16 at 3:35 p.m. that "he was nervous and forgot to wash his hands." 5. On 11/2/16 at 7:58 a.m. during medication pass observations, Licensed Nurse 7 (LN 7) completed her administration of morning medications and after exiting the resident's room, placed her dirty stethoscope and blood pressure cuff on the crook of the sharps container located on the side of the medication cart. She proceeded to take bleach wipes from the bottom	F 441		

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F 441	Continued From page 27 drawer of the medication cart and clean the blood pressure cuff and stethoscope. She then placed the cleaned medical devices back onto the dirty surface of crook of the sharps container.	F 441	F-456 1. The raised area identified in the kitchen was fixed on 11/29/16. 2. The rubber area identified in the kitchen area was fixed on 11/29/16. 3. The cracked tile in the kitchen area was fixed on 11/30/16. The Facility administrator in serviced the maintenance supervisor on performing monthly facility rounds and making necessary repairs on 11/30/16. Monthly times 3 months then quarterly thereafter, the facility administrator along with the maintenance supervisor, will make round through out the facility to identify areas that may need repair and have repairs completed as needed. The maintenance supervisor will report any non compliance issues to the quality assurance committee for recommendations as needed.	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and sanitary floor in the kitchen. This failure had the potential infection risk and potential to jeopardize the safety of those entering the kitchen. Findings: During the Environmental Tour of the facility on 11/2/16 beginning at 3:00 p.m., accompanied by the Maintenance Supervisor (MS), the following was observed in the kitchen service area located between the main kitchen and the dining room: 1. In the far corner of the room adjacent to the outside wall and the dining room, a large square approximately 10 inches by 10 inches and raised approximately 3 inches off the ground was noted. When the tray carts are not in use, it was observed that they are stored in this area to cover the protruding object. However, when the carts are in use, the object is exposed. In a concurrent interview with the MS, he stated the object was the old drain from the old small ice machine, "We	F 456		

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F 456	Continued From page 28 store the carts here, so no one trips over it." When the carts are not in the area, there is nothing to mark it as a potential tripping hazard. 2. In the far corner of the room adjacent to the outside wall and the dining room, the rubber wall cover was not attached to the wall with staining and peeling wall board noted. In a concurrent interview the MS stated that it would need to be repaired. 3. The tile in front of the ice machine by the right base was cracked with some loose pieces noted. In a concurrent interview, the MS stated the tile would need to be repaired.	F 456	F-463 The call light system by station 1 was adjusted on 11/8/16 to produce an audible sound. The DSD in serviced the staff on 11/28/16 through 11/30/16 to ensure they respond to the call lights and the audible call system to meet our residents' needs in a timely manner. The maintenance department will perform daily rounds times one week, weekly rounds times 4 weeks then monthly thereafter to verify that the call system remains audible. Any discrepancies will be reported to the facility administrator for follow up as needed. The maintenance supervisor will report any non compliance issues to the quality assurance committee for recommendations as needed.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to equip Station 2 with an audible resident call system. This failure caused residents to wait for long periods of time before their call lights were answered. Findings: On 11/8/16 at 9:05 a.m., the call light response time was being monitored at Nursing Station II. The light above Room #310 was on, and staff were observed passing by the room without	F 463		

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F 463	Continued From page 29 entering or asking if anyone needed assistance. At the nursing station, there was no audible sound indicating that a call light was ringing or buzzing. The Speech Therapist (ST), who was documenting at the nursing station at the time, was asked if she heard a sound like a ringing call light. She replied, "I don't here any sounds. Should there be one?" When a second call-light lit up above another residents' room down the opposite side of the hall, and no sound was heard at the nursing station, a search for the nursing call light panel at the nursing station was conducted. Both lights were observed staying on for over 10 minutes without being answered. Neither of the two rooms with their call lights on triggered a sound at the nursing station. The call light panel, which was found mounted on the wall behind the nursing station, was observed with the volume knob set on "Low." The sound emitted at the low position was so faint that no audible sound was heard unless one was standing by the wall, with an ear next to the panel. During a subsequent observation at 11 a.m., accompanied by the Director of Nurses (DON), she confirmed that a couple of resident call lights above resident rooms in Station II, were "On." However, when we approached the nursing station, the sound was very faint and could not be easily heard with the minimal surrounding noise. As the DON approached the wall-mounted call light panel, she placed her ear close to the panel and moved the knob from "Low" to "High." In doing so, immediately an intermittent buzzing sound was heard at a low to medium volume. When the volume knob was switched back to	F 463		

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F 463	Continued From page 30 "Low," another surveyor standing at the nursing station confirmed that she could not hear any buzzing sound. The facility's policy and procedure titled, "Answering the Call Light," revised August 2015, indicated that, "Be sure that the call light is plugged in at all times." And, "Answer the resident's call as soon as possible."	F 463	F-514 The isolation order for resident 13 was discontinued on 11/1/16. The MRD/designee will complete a review of resident orders by 12/2/16 to verify orders are current and necessary. Any discrepancies will be forwarded to the providers for correction. The DON in serviced the LN on 11/28/16 & 11/30/16 regarding discontinuing order when the resident condition is resolved. Orders for discontinuation will be obtained from the providers. Weekly times 4 weeks then monthly thereafter the MRD/designee will perform 10 random EMAR audits to check and verify accuracy in current orders. The audits will be given to the DON for follow up as needed. Monthly the Nursing Management team will review resident orders to verify they reflect the current resident assessment. Any discrepancies noted will be forwarded to the providers for correction.	
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 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to maintain complete and accurate information on one resident's clinical record, when orders for isolation were not being followed. This failure reflected an inaccurate assessment of the resident affecting his plan of care, placing other residents and family members at risk of cross contamination.	F 514		

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F 514	Continued From page 31 Findings: Resident 13 was admitted to the facility on 10/9/15 with diagnoses of traumatic subdural hemorrhage, difficulty walking and muscle weakness. A few months after admission, he developed symptoms of shingles and was placed on contact isolation for his skin lesions, on 2/2/16. Following a 30 minute interview with the resident, conducted on 11/1/16 at 4 p.m., the resident was observed sitting up in his wheelchair. He was also observed to be free to leave his room at his own free will, and had access to various parts of the facility. When Resident 13's clinical record was reviewed on 11/1/16, it was discovered that the resident had current orders to be in isolation. However, there was no Contact Isolation sign on his door warning those entering his room, and no restrictions on his whereabouts through out the facility. The order, dated 2/2/16 read, "Maintain Contact Isolation until Shingles lesions dry out..." On 11/2/16, after not finding a current assessment on the shingles, in an interview with the facility's Nurse Practitioner (NP), he was asked if the resident still had shingles and, should he still be in contact isolation. After glancing through the resident's clinical record, he came to an entry dating back several months ago (2/18/16) that the resident had been cleared of shingles and was no longer contagious. However, the NP later added that the isolation order written on 2/2/16, remained active and was never discontinued in the clinical record.	F 514	The DON will report any non compliance issues to the quality assurance committee for recommendations as needed.	