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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056215	A. BUILDING ______ B. WING ______	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBROOK HEALTHCARE CENTER	64 NORTHBROOK WAY WILLITS, CA 95490

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an annual Recertification Survey, 4/22/14-4/25/14. Health Facilities Evaluator Nurses: 32887, 14607, 33028, 32924 and 11822. The facility census on the day of entry, 4/22/14, was 39 with no bed holds. The sample size was 10 sampled residents. There were no entity-reported events or complaints investigated during the survey.	F 000		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, licensed staff did not follow professional standards of practice when they failed to sign the Medication Administration Record (MAR) following the administration of scheduled medications for 1 of 10 sampled residents (Residents 9). This failure has the potential to result in medication errors due to the inability to determine whether the medication was administered. Findings: During a review of the clinical record for Resident	F 281	F281 Nurses' signature log completed. 4/25/14 All residents had the potential to be affected. Facility has changed to Electronic Medication Administration and Electronic Treatment Records. 5/12/14 Licensed nurses received in-service by Director of Nursing Services on Medication Administration Record and Treatment Administration Record documentation; including but not limited to need for signature bottom of records or completion of signature log. 4/24/14	4/25/14 5/12/14 4/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator revised — (X6) DATE 6/25

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.

RECEIVED JUL 01 2014 CDPH L&C Santa Rosa D.O

6/30/14 - accepted POC - spoke with Shawnee Bonfle administrator 345PM
32887/HFEN

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F 281	Continued From page 1 9, the MAR dated 4/1/14 - 4/30/14, indicated treatments and medications Resident 9 was scheduled to receive. Each page revealed an absence of the nurse's signature and title. In all instances, the missing signatures were not accompanied by any explanation as to their absence. Results of the Review of Resident 9 ' s MARs: The 12:00 p.m. doses of Keflex (a medication for the treatment of infection) lacked signatures for the dates of 4/22 and 4/23. The 6:00 p.m. doses of Keflex lacked signatures for the dates of 4/22 and 4/23. The 5:00 p.m. doses of Coumadin (a medication for blood thinning) lacked signatures for the dates of 4/18, 4/19, 4/20, 4/21, 4/22 and 4/23. The 5:00 p.m. central line flushes with 10 ml Normal Saline (a flushing medication for the percutaneous intravenous central catheter PICC) lacked signatures for the dates of 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22 and 4/23. The 8:00 a.m. doses of Celexa (a medication for depression) lacked signatures for the dates of 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22 and 4/23. The 3:00 p.m. doses of Ertapenem IV (a medication for the treatment of infection) lacked signatures for the dates of 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22 and 4/23. The 8:00 a.m. doses of Prednisone (a medication	F 281	Director of Nursing Services and Clinical Resource provided In-services to Licensed Nurses on Electronic Medication Administration and Electronic Treatment records. 5/7/14 Signature log will be maintained by Medical records and updated with all newly hired licensed nurses. The log will be ongoing. 5/25/14 Director of Nursing Services will review logs monthly and as needed for the period on 3 month and report findings to Quality Assurance Committee to ensure that the protocols set forth within these corrective measures are followed. 5/25/14	5/7/14 5/25/14 5/25/14

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F 281	Continued From page 2 used for arthritis) lacked signatures for the dates of 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22 and 4/23. The 8:00 a.m. and the 4:00 p.m. doses of Oscal (a medication used as a dietary supplement) lacked signatures for the dates of 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22 and 4/23. The 10:00 a.m., 2:00 p.m., and 8:00 p.m. doses of Baclofen (a medication used for pain related to infection) lacked signatures for the dates of 4/13, 4/14, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21 and 4/23. The 8:00 a.m., 2:00 p.m., and 8:00 p.m. doses of morphine sulfate (MS) contin (a medication used for pain) lacked signatures for the dates 4/13, 4/14, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21 and 4/23. The as needed dose of Oxycodone (a medication used for pain) lacked a signature for the date of 4/20. The as needed dose of Dulcolax (a medication used for constipation) lacked a signature for the date of 4/18. The as needed dose of Milk of Magnesia (a medication used for constipation) lacked a signature for the date of 4/14, 4/17 and 4/23. The facility policy and procedure titled "Medication Administration MAR and TAR Documentation" dated Revised 10/2013, indicated, "The nurse who administers the medication or treatment shall record his/her initials in the appropriate box on the medication or treatment record. Initials are to be identified with	F 281		

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F 281	Continued From page 3 the nurse's signature and title on each page of the form that the initials are recorded. An alternate method would be a master list of all licensed nurses signatures and their initials to be maintained by medical records." During an interview and document review with Administrative Staff B, on 4/24/14, at 11:20 a.m., when shown the copies of the MARs on which signatures were missing, she acknowledged that they were not there and they should be. When asked what is the expectation related to the documentation of medication administration, Administrative Staff B stated the nurses should sign the MAR as soon as the medication is given. She also stated she had a master list of all the licensed nurses' signatures and their initials in Medical Records. When provided the Master Licensed Nurses Signature Log Administrative Staff B acknowledged the master list was incomplete. Clinical Nursing Skills and Techniques, "Medications Orders," Perry, Potter & Ostendorf, 2014, p. 52, indicated that all entries in medical records should be dated and that a method be established for identifying the authors of entries. "Records need to reflect accountability...The signature holds that nurse accountable for information recorded."	F 281		
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	F 309	F309 Resident Care Plan was updated to include PICC, infection and IV Antibiotics. 4/24/14 All residents have the potential to be affected.	4/24/14

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F 309	Continued From page 4 and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record and facility policy review, the facility failed to update the Care Plan for 1 of 10 sampled residents (Resident 9) who had a percutaneous intravenous central catheter (PICC) and was actively being treated with intravenous (IV) antibiotics for a postoperative infection. This failure had the potential to cause the resident physical decline and possible death. Findings: During an interview on 4/24/14, at 1:35 p.m., Administrative Staff J stated the care plan is updated/modified by each discipline responsible for the type of issue identified. Review of the History and Physical for Resident 9 dated 4/10/14 indicated the following information regarding Resident 9's history of present illness " ...a history of an infected right total hip status post several total hip revisions most recently by [Confidential Independent Physician]...on 2/27/14 ...He was discharged with the plan for further daily IV Ertapenem for the next 4 - 6 weeks ... " Review of the Care Plan Report dated 4/12/14, for Resident 9, indicated nine focus areas with goals, interventions, and target dates. The Care Plan Report did not address a focus area regarding the PICC, infection and IV antibiotics	F 309	New admission audit and change of condition audit will be completed by Medical Records as needed to include care planning on an ongoing basis. 5/24/14 Director of Nursing Services and Clinical Resource provided In-services to Licensed Nurses on Care Planning and Checklist.. 5/22/14 Care Plan Audit will be reviewed at stand-up meetings/clinical meetings on an ongoing basis and will be communicated to staff as needed by Medical Records and/or Director of Nursing Services verbally and/or in writing to specific nurses for follow-up on an ongoing basis. 5/25/14 New admission checklist update to include specific care plan triggers for licensed nurses for follow-up and nurses received education on the checklist changes and checklist will be completed on an ongoing basis. 5/25/14 Minimum Data Set Nurse and Director of Nursing Services will monitor completion of comprehensive care plan due by day 21on an ongoing basis.5 /.25/14	5/24/14 5/22/14 5/25/14 5/25/14 5/25/14

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F 309	Continued From page 5 treatment. The facility policy and procedure titled "Care and Treatment, Care Planning" Revised 04/2013, indicated "It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident ...The care plan is developed by the IDT which includes, but is not limited to the following professionals: A. Attending Physician B. Registered Nurse responsible for the resident ...H. Director of Nursing Services (as applicable) ..."	F 309	Director of Nursing Services will report on finding of audit and checklist changes at least quarterly at Quality Assurance Committee for the period of 3 months to ensure that the protocols set forth within these corrective measures are followed. Finding will be reviewed at Licensed Nurses meeting and a copy of the Quality Assurance Meeting report will be posted in Staff area within a week of the meeting. 5/25/14	5/25/14
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1.Hot Water turned back on at sink base. 4/22/14 2.Ice Machine was re-cleaned on 4/23/14 3.Improper stored food items were discarded.4/22/14 4.Can opener was cleaned by dietary staff.4/22/14 All residents have the potential to be affected. 1.Handwashing in-services provided to dietary staff by Registered Dietician, including but not limited to sink temp. 4/21/14	4/22/14 4/23/14 4/22/14 4/22/14 4/21/14
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared and served under sanitary conditions when: 1. The water in the kitchen staff-handwashing sink was cold. 2. Ground turkey was improperly thawed. 3. The facility ice machine had a "slimy" black			

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F 371	Continued From page 6 substance inside the ice dispenser. 4. Turkey pastrami was not stored correctly in the refrigerator. 5. Frozen cauliflower and pearl onions were improperly stored in the freezer. 6. Spoiled produce was found in a dry storage box. 7. Bulk sugar, flour and rice was stored in bins with non-food grade plastic liners. 8. The can opener had a brown "sticky" substance on it. These failures had the potential to cause cross-contamination and food-borne illness for the 39 residents who ate meals prepared in the kitchen, by the dietary staff. Findings: 1. During the initial kitchen tour on 4/22/14, at 8:07 a.m., cold water came out of the staff-handwashing sink faucet, located approximately one foot to the left of the kitchen entry door. The water from the mixed sink faucet (refers hot and cold water combined in a faucet or spout) ran for over two minutes and remained cold at 62.4 degrees Fahrenheit. During an interview with Dietary Staff W, on 4/22/14, at 8:30 a.m., she washed her hands at the kitchen staff-handwashing sink and stated, "It's cold, I usually use the other sink over there." (pointing to a sink about 15 feet into the kitchen, adjacent to a food preparation area and stove) During an interview with Administrative Staff F, on 4/22/14, at 10:49 a.m., she confirmed that cold water was coming from the staff hand-washing sink faucet, at 62.4 degrees Fahrenheit.	F 371	Am cook to check that the hot water is "on" in am and recorded on temperature log. 5/25/14 Certified Dietary Manager to monitor logs weekly for 3 months and then monthly for an ongoing basis. 2.Maintenance Supervisor to develop checklist for ice machine cleaning to assure all steps are taken for cleaning completeness. Checklist to be used for each cleaning by Maintenance Director on an ongoing basis. 5/25/14 Administrator will sign-off on the cleaning checklist once completed each month. 3.Dietary Staff in-services on thawing and storage of raw meat and food storage; including dry storage, produce, refrigerator and freezer storage. 5/21/14 Thawing temp sheet developed: Recording date item pulled from freezer, the time it began thawing in the sink (only when this is necessary), the temp of the water running into the pan with meat submerged in the water. 5/21/14	5/25/14 5/25/14 5/25/14 5/25/14 5/21/14

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F 371	Continued From page 7 Administrative Staff F then turned a valve below the sink, which allowed hot water to enter the sink faucet and stated, "The night dietary aide turns off the hot water, and he had been talked to about it." According to the 2013 Federal Food Code, Sections 5-202.12 and 5-205.11, a handwashing sink is to provide water at least 100 degrees Fahrenheit through a mixing or combination faucet, and a handwashing sink may not be used for purposes other than hand handwashing. 2. During a kitchen observation on 4/22/14, at 8:17 a.m., a plastic tube of frozen ground turkey was thawing under warm running water at 74.8 degrees Fahrenheit, not completely submerged in a shallow metal pan of water. In a concurrent interview, Dietary Staff X confirmed that the water temperature was 74.8 degrees Fahrenheit. During an interview with Dietary Staff W, on 4/22/14, at 8:31 a.m., when she was shown the thawing ground turkey, Dietary Staff W removed it from the warm water and stated, "I should have taken it out. It should be under 70 degrees Fahrenheit." The facility policy titled, "Thawing of Meats", undated, page 7.4, indicated, "...3. Submerge under running, potable (drinkable) water at a temperature of 70 degrees Fahrenheit or lower..." 3. During an interview with Administrative Staff I, on 4/22/14, at 3:46 p.m., in the staff break room, he pointed to the facility ice machine and stated that it was was accessed by the dietary and nursing staff for resident use. Administrative Staff I also stated that he cleaned the machine	F 371	Proper freezer storage Policy and Procedure was posted on refrigerator and freezer for staff review and reminder. Produce storage guidelines posted on produce refrigerators. Policy and procedure and guidelines to remain posted and updated as needed. 5/21/14 A "Fully Ripe Date" in on the side of the banana box and a piece of tape with each weeks date when the bananas are fully ripe, will go on the label. 5 days later, any remaining bananas will be thrown away. This is an ongoing procedure. 5/21/14 Cooks or Certified Dietary Manager will check for any skin openings as bananas are used on an ongoing basis. Can opener to be cleaned after each use and is on cleaning schedule for am and pm cook. 5/25/14 Cleaning schedule will be checked by Certified Dietary Manager on her schedule days for completeness and will do weekly cleaning checks on an ongoing basis. 5/25/15 RD will complete Sanitation rounds monthly including, but not limited to cleanliness of can opener and other appliances.	5/21/14 5/21/14 5/21/14 5/25/14 5/25/14 5/25/14

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F 371	Continued From page 8 monthly, and an outside company representative cleaned the machine every six months. When a white paper towel was wiped inside the ice dispenser, (where ice comes out of the machine) a "slimy" brownish black substance was noted on the towel. Administrative Staff I observed the brownish black substance and stated, " I can't believe how dirty that got since it was cleaned. I need to clean it more often." During a subsequent interview with Administrative Staff I, on 4/23/14, at 2:15 p.m., he stated that he missed cleaning the ice dispenser portion of the ice machine. The facility policy and procedure titled, "Ice Machine Cleaning", dated August 22, 2006, indicated, "It is the policy of this facility to ensure the ice machine is cleaned and sanitized on a regular basis to provide a sanitary environment and prevent the potential for transmission of infection. Procedure: Semi-Annually The Ice Machine and water lines will be cleaned and sanitized by a contracted service...Monthly: the ice machine interior and exterior will be cleaned (Maintenance Supervisor)..." 4. During a kitchen observation on 4/22/14, at 8:22 a.m., two Jenny O (brand name) turkey pastramis were stored in open bags, dated 4/14/14, leaking clear brown "sticky" liquid into a shallow uncovered pan, inside the refrigerator. During an interview with Dietary Staff W, on 4/22/14, at 8:33 a.m., when shown the uncovered turkey pastramis, Dietary Staff W discarded them and stated, "It's out of date, that's garbage, I'll throw it out."	F 371	Food-grade bag/liners ordered by Certified Dietary Manager. Bins are cleaned and sanitized between each usage and date labeled. Items can be stored in cleaned and sanitized bins without liners, if liners are unavailable. 4/24/14 Certified Dietary Manager or designee will check storage and retention systems/logs and cleaning schedules on her scheduled days. Registered Dietician will check storage and retention systems/logs and cleaning schedules every month with sanitation rounds on an ongoing basis. Registered Dietician will report findings of compliance, system changes and follow through on rounds in writing to Administrator every month. Certified Dietary Manager or Registered Dietician will report findings of logs/schedules/rounds at least quarterly to Quality Assurance Committee to ensure the protocols set forth within these corrective measures are followed. Finding will be reviewed at Department Meeting and A copy of the Quality Assurance Meeting report will be posted in Staff area within a week of the meeting. 5/25/14	4/25/14 5/25/14 5/25/14 5/25/14

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F 371	Continued From page 9 The facility procedure titled "Procedure for Refrigerated Storage" undated, pages 6.11-6.12, indicated, "...5. Food should be covered...9. food items should be arranged so that older items will be used first...All refrigerated foods are to be kept the amount of time per 'Refrigerated Storage Guidelines...." 5. During a kitchen observation on 4/22/14, at 8:20 a.m., one bag of frozen cauliflower and three bags of frozen pearl onions, that had been previously opened, were stored in the freezer without dated labels. White frost build-up [also known as freezer burn] was noted on the cauliflower. During an interview with Dietary Staff W, on 4/22/14, at 8:32 a.m., when she was shown the cauliflower and pearl onion bags in the freezer and asked when they were opened, Dietary Staff W stated, "They usually put masking tape with dates, and they must have come off. I believe it was March 31st." During an interview with Administrative Staff F, on 4/22/14, at 10:58 a.m., when she was asked about the opened bags of cauliflower and pearl onions in the freezer, she discarded them and stated, "We'll throw these away...No they are not labeled." Review of the facility procedure titled "Procedure for Freezer Storage" undated, page 6.16, indicated, "...5. Store frozen foods in an airtight moisture resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. 6. All frozen food should be labeled and dated.	F 371		

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F 371	Continued From page 10 6. During a kitchen observation on 4/22/14, at 8:13 a.m., a box of approximately 50 bananas on a lower shelf near the oven had black spots covering more than 50% of the banana skins. Four bananas had a whitish "fuzzy" material on their cracked-open skins, which revealed a yellowish brown inner fruit. During an interview with Administrative staff F, on 4/22/14, at 10:53 a.m., when she was shown the blackened bananas with whitish fuzzy material on their cracked-open skins, Administrative Staff F discarded two bunches of the bananas and stated, "We wouldn't use these." The facility policy titled, "Storing Produce" dated March 2013, page 6/14, indicated, "1. Check boxes of fruit and vegetables for rotten items. One rotten tomato, apple or potato in a box can cause the rest of the produce to spoil faster. Throw away all spoiled items....5. Bananas should be stored at room temperature. When fully ripe, bananas may be stored in the refrigerator for 5 days, as long as they have no open skins..." 7. During a kitchen observation on 4/22/14, at 10:55 a.m., with Administrative Staff F, loose rice, flour, sugar and other bulk food was stored in 5-gallon bins with white plastic liners. During a concurrent interview when she was asked if they were food-grade liners, (liners that will not transfer noxious or toxic substances to food it is holding) Administrative Staff F stated that she didn't know, and that she never heard of that. During a housekeeping storage area observation on 4/22/14, at 11:16 a.m., Administrative Staff F pointed to the box of plastic liners used to store	F 371		

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F 371	Continued From page 11	F 371		

the loose rice flour, sugar and other food items in the 5-gallon bins. The liner box titled, "DraStar by Waxie Corless Roll liners 40X48 Natural" did not indicate anywhere on the label that they were were food-grade liners.

During an interview with Administrative Staff E, on 4/23/14, at 11:15 a.m., she acknowledged the importance of using only food-grade plastic liners, if they are used to store food, and stated she was ordering food-grade plastic liners.

The facility policy titled, "Storage of Food and Supplies" undated, page 6.4, indicated, "...6. Dry bulk foods (flour, sugar, dry beans..) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized..."

According to the United States Department of Agriculture (USDA), the use of plastic trash bags is not recommended for food storage or cooking "...because they are not food grade plastic and chemicals from them may leach into the food." http://www.fsis.usda.gov/oa/pubs/meatpack.htm

8. During a kitchen observation on 4/22/14, at 8:35 a.m., the can opener that was mounted on counter had a brownish "sticky" substance on it near the blade. In a concurrent interview, when shown the brownish "sticky" substance, Dietary Staff W stated, "It's dirty, I'll clean it."

The facility procedure titled, "Can Opener and Base" dated 3/13, page 8.27, indicated, "Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation...1. The can opener must be thoroughly cleaned each work shift and, when

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F 371	Continued From page 12 necessary, more frequently..."	F 371		
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 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: 1. Provide accurate medication dispensing services, for one randomly observed resident (Random Sample Resident 11) in a sample size of 10 residents. This failure had the potential to lead to inaccurately administered medications and 2. For 1 of 7 emergency medication kits (E-kits), the facility failed to supply an accurate	F 425	F425 "Medication direction change see chart" sticker was placed on medication and medication re-ordered. 4/23/14 Emergency kits were replaced by pharmacy 4/24/14 All residents receiving medications have the potential to be affected. Pharmacist-in-Charge of Skilled Nursing Pharmacy – Hayward reviewed the E-Kit process and made the necessary changes in the verification process to include a double check of quantity count and expiration dating by the Pharmacist. 4/24/14 Education by Pharmacist-in-Charge to be provided to both Pharmacy Technicians involved with staging of emergency kits and Staff Pharmacist for accurate documentation of quantity, availability and expiration date of the contents of the emergency kit, follow-up In-service to be provided as needed.. 4/24/14	4/23/14 4/24/14 4/24/14 4/24/14

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F 425	Continued From page 13 intravenous (IV) supply inventory when 10 of 44 IV supplies in the E-Kit (#606) were mislabeled. This failure had the potential to delay treatment to any resident and could potentially result in adverse consequences. Findings: 1. During an observation on 4/23/14, at 6:50 a.m., in the doorway of Room 3A, the medication administration observation, Licensed Staff N administered twelve different medications to Random Sample Resident 11. Review of the medication card indicated Random Sample Resident 11 was to receive Prednisone (a medication used for arthritis) 5 milligram (mg) 1 tab by mouth every day and Prednisone 1 mg 8 tabs by mouth every day. Review of the Order Summary Report on 4/23/14 revealed the prescriber's order dated 3/29/14, Prednisone 9 mg by mouth every day. During an interview on 4/23/14, at 8:30 a.m., Licensed Staff N indicated that she administered Prednisone 5 mg one tab and Prednisone 1 mg 4 tabs (not 8 as labeled) this morning. She stated she would contact the pharmacy to request the re-labeling of the Prednisone 1 mg tablets. 2. During an observation and document review on 4/23/14, at 8:20 a.m., in the nursing station medication room, the following "IV Supplies Emergency Kit" (E-kit) inventory list (maintained by the pharmacy service and placed on the outside of the E-kit) revealed several mislabeled contents: A) The expiration date for two Peripheral IV Start Kits was 03/2017 on the inventory list; however,	F 425	Director of Nurses conducted an in-service for Licensed Nurse on the "Six Rights of Medication Administration" 5/22/14 Pharmacy Nurse Resource, Director of Nursing Services or Director of Staff Development will complete Nurse Medication pass observations with all newly hired nurses and annually for all nurses on an ongoing basis. 5/25/14 Pharmacy Consultant and/or Director of Nursing Services will report on med pass observations to Emergency Kit accuracy to Quality Assurance Committee to ensure that the protocols set forth within these corrective measures are followed. . Finding will be reviewed at Licensed Nurses meeting and a copy of the Quality Assurance Meeting report will be posted in Staff area within a week of the meeting. 5/25/14	5/22/14 5/25/14 5/25/14

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F 425	Continued From page 14 the dates on the package label were 04/2016 and 03/2015. B) The expiration date for two Introcan Safety IV Catheter 22 G was 04/2015 on the inventory list; however, the date on the package label was 08/2018. C) The expiration date for six Introcan Safety IV Catheter 24 G was 08/2018 on the inventory list; however, the dates on the package label were two for 04/2018, two for 12/2017 and two for 12/2018. During an interview on 4/23/14, at 8:45 a.m., Administrative Staff B confirmed that the supply expiration dates were incorrect on the inventory list and she did not know about it before opening the E-Kit. During an interview on 4/23/14, at 10:30 a.m., Administrative Staff B stated that she spoke with the ~~contracted pharmacy~~ and the contracted pharmacy will replace the 7 E-Kits.	F 425	F456	
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, interview and record review the facility failed to ensure that one of two washing machines does not leak water on the floor, between 4/22/14 and 4/25/14, for a census	F 456	Hose was temporarily repaired and hose ordered. 4/22/14 Repair completed on 4/28/12 All residents have potential to be affected. Maintenance will develop monthly and as needed schedule and log for wash machines preventative maintenance to include, but not limited to proper functioning and leaks on an ongoing basis. 5/25/14	4/22/14 4/28/14 5/25/14

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F 456	Continued From page 15 of 39 residents. This failure has the potential for residents not having access to linens and clothing in a timely manner which could result in a decline of their physical health and safety. Findings: During an observation of the laundry room, on 4/22/14, at 9:00 a.m., the washing machine for the residents' personal clothing was leaking water from the door handle and on the floor was a wet towel. The back of the washing machine had more than a handful of lint on the floor and the floor was dirty. During an interview, on 4/22/14, at 9 a.m., Staff Z stated that the floor was wet because sometimes the washing machine leaks. During observation and concurrent interview on 4/23/14, at 11:12 a.m., in the laundry room, observed a small puddle around the drain between washing machines, acknowledged by Administrative Staff I, who said there was a leak reported and there might be a hose that he needs to address. During an observation on 4/24/14, at 8:50 a.m., in the laundry room, the washing machine for the residents' personal clothing was filled with clothing and not running. A bath blanket was on the floor between the washing machines. Administrative Staff I was present, removed a front panel from the machine, under which was a puddle of water. During a subsequent interview on 4/24/14, at 8:50 a.m., Administrative Staff I stated that he was	F 456	Log will be reviewed and signed by Administrator on completion on schedule preventative maintenance on an ongoing basis. 5/25/14 Maintenance Supervisor will review Log findings at least quarterly at Quality Assurance Committee on an ongoing basis to ensure that the protocols set forth within these corrective measures are followed. Finding will be reviewed at Department meeting and a copy of the Quality Assurance Meeting report will be posted in Staff area within a week of the meeting. 5/25/14	5/25/14 5/25/14

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F 456	Continued From page 16 looking to find the source of the leak so that he can order the part as soon as possible and repair it. During an interview on 4/25/14, at 9:30 a.m., Administrative Staff I stated that the washing machine leak was due to a hose that he fixed temporarily to stop the leak. The washing machine was not running and had no clothes inside. During an interview with Administrative Staff I, on 4/25/14, at 1:20 p.m., in the laundry room, He stated that he placed an order to replace the hose that was leaking from the washing machine for the residents' personal clothing, and that he placed duct tape around the leaky hose yesterday. During a review of the washing machine manufacturers guideline titled, "Maintenance," Section VI, page 39, indicated on section VI. (2) Daily (E) "Check loading door for leaks. Clean the door seal of all foreign matter. VI. (3) Monthly (C) "Check all water connections and hose connections for leaks. Tighten or replace as needed." Under "Caution" box, it indicated, "..., take care when doing any maintenance or making any check or repair. Follow manufacturer's instructions for all materials used during service and maintenance of this machine. If used or handled improperly, they can be hazardous. Improper or incomplete service can also affect the machine and result in personal injury, or damage to the machine ..." During a review of the Maintenance Supervisor job description, under the section, "Equipment and Supply Functions", it indicated, "Monitor	F 456		

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F 456	Continued From page 17 maintenance procedures to ensure that supplies are used in an efficient manner to avoid waste." Under the section, "Specific Requirements", it indicated, "Must maintain the care and use of supplies, equipment, etc., and maintaining the appearance of work areas...and proper performance of equipment."	F 456		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment for a census of 39 residents when: 1. An incinerator containing biohazard sharp containers was left unlocked. 2. Shower chairs used for bathing residents were stored outside, exposed to the weather. 3. Side of the building driveway had multiple construction equipment and debris. 4. The residents' smoking patio had a round table with broken chairs used for activities. These failures had the potential to result in getting cuts, skin tears, falls, insect bites and/or illnesses for residents with compromised health status. Findings: During the initial tour of the facility, on 4/22/14, at	F 465	F465 Biohazard container locked and sign placed for it to remain locked. 4/25/14 Shower chairs cleaned and inspected prior to facility usage. 5/24/14 Equipment and debris was cleaned and removed. 4/30/14 Damaged Chairs were discarded.4/25/14 Residents and visitors going to back or side of facility have the potential to be affected. Facility safety rounds form updated to include, but not limited to checking of biohazard storage security, clutter and debris of facility surroundings and safe and sanitary storage of equipment. 5/25/14	4/25/14 5/24/14 4/25/14 5/25/14

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F 465	Continued From page 18 8:40 a.m., the following was observed: 1. There was a rusted (reddish substance that forms on iron when it comes in contact with moisture) incinerator with an unlocked padlock. The incinerator stored a red bin that contained biohazard sharp containers covered with a red plastic bag. During an interview, on 4/23/14, at 8:30 a.m., Administrative Staff I stated that the incinerator is kept unlocked. During an interview, on 4/25/14, at 10 a.m., Administrative Staff A stated that the incinerator should be locked and that even though the facility has a 'No trespassing' sign in driveway that the neighborhood children still come and play in the driveway by the incinerator. The facility policy and procedure titled "Waste Management, Infectious" dated 5/2007, indicated the policy objective is to decrease the potential of exposure to hazardous waste by appropriate management and disposal. Procedure I (1) (D) indicated, '1. OSHA has defined regulated waste to include: D. Contaminated sharps (needles, lancets, scalpel blades)."The Procedures II indicated how to place the sharps into the puncture resistant containers to eliminate the hazard of physical injury and how to make sure that the sharps containers are not overfilled. Procedure IV, titled 'Other Wastes' indicated, "4. Final disposal of waste will be in accordance with local, state and federal regulations. Many facilities contract with a waste disposal company to collect, transport, and dispose of the waste." The facility policy and procedure titled, "Waste	F 465	Facility rounds will be completed on a monthly basis by assigned Department Managers for the period of three month and then rotating areas will be rounded on each quarter. 5/25/14 Department managers will be educated on round requirements by Maintenance Director. 5/25/14 Findings of rounds will be communicated on round sheets to Environmental Services for corrections/repairs. 5/25/14 Administrator will sign-off on all round sheets when completed on an ongoing basis. 5/25/15 Maintenance Director will review log findings at least quarterly on an ongoing basis at Quality Assurance Committee to ensure that the protocols set forth within these corrective measures are followed. Finding will be reviewed at General Staff Meeting and a copy of the Quality Assurance Meeting report will be posted in Staff area within a week of the meeting.. 5/25/14	5/25/14 5/25/14 5/25/14 5/25/14 5/25/14

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F 465	Continued From page 19 Disposal, Infections," dated 6/2007, indicated procedures for disposing of infectious waste safely. The procedures indicated that 'Infectious medical waste' included cultures, human pathological waste, human blood and items saturated with blood, used sharps, discarded unused sharps, contaminated animal carcasses, and wastes from residents in isolation. Procedure 2, indicated, "'Disposal of sharps' to place in sharps container, place in red plastic bag and/or bag that display the universal biohazard symbol, bags must be sealed and placed in a rigid cardboard box." Please note: There was no policy and procedure about how and where to store biohazard waste. 2. There was an outside stack of shower chairs that were partially covered and exposed to weather conditions. During an interview, on 4/23/14, at 8:30 a.m., Administrative Staff I stated that the shower chairs in the driveway are not cleaned. The chairs are disinfected on a need to use basis with a disinfectant cleanser monitored by ECOLAB. During an interview, on 4/25/14, at 10 a.m., Administrative Staff A stated that the excess equipment should be disposed and that the shower chairs should all be disposed. Review of the policy and procedure titled, "Cleaning and disinfection of wheelchairs, stretchers," dated 3/2009, indicated how to clean and disinfect. There was no procedure as to where to store the shower chairs. 3. The facilities' side driveway was surrounded	F 465		