STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	C 03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER FAIR OAKS	11300 FAIR OAKS BLVD. FAIR OAKS, CA 95628

OK 4/6/15 CE

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification Survey. Representing the Department of Public Health: HFEN, 29917 HFEN, 29108 HFEN, 33361 HFEN, 32476 HFEN, 33423 The facility census was 145 and the resident sample size was 24. Entity Reported Incident #CA00434668 was investigated during the recertification survey. There were no violations of regulations identified for this entity reported incident.	F 000	Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulation (CFR).	
F 160 SS=E	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and financial record review, the facility failed to convey the personal funds deposited with the facility to the appropriate parties within 30 days, and give a final accounting of those funds for 5 of 11 random residents (RRs J, K, and L) upon death of the residents, and	F 160	F 160 • Refunds for Residents H, J, K, & L were allocated on the 11th of March during the survey process. Resident I's refund of $6.00 is pending due to the inability to locate immediate family. • No other residents were affected, since all residents with balances were requested during the survey process. • A monthly audit, we be conducted by the 4th week of each month by the Business office manager. The purpose	4-13-15

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

Administrator 4/2/2015

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 160	Continued From page 1 (RRs H and I) upon discharge. This failure resulted in funds not being returned to the appropriate parties within the 30 day required time frame, and the appropriate parties not given a final accounting of the funds. Findings: During a review of the residents' trust accounts on 3/12/15, at 2:55 p.m., there were five accounts remaining in an open status for residents who were either deceased or discharged from the facility. Accounts with balances for deceased and discharged residents: RR H (discharged on 8/15/14) balance: $30.00 RR I (discharged on 7/6/13) balance: $6.00 RR J (deceased on 2/1/15) balance: $30.01 RR K (deceased on 12/25/14) balance: $240.31 RR L (discharged on 12/8/14) balance: $5.00 During a concurrent interview with the Business Office Manager (BOM), she stated the accounts should have been closed within 30 days of the residents leaving the facility, and a final accounting of the funds given to the appropriate parties. BOM confirmed there was no documented evidence of the facility's attempts to	F 160	of the audit will be to identify discharged residents having trust balances and to ensure that all money is returned to the responsible party within the 30 day window. This audit will be monitored by the QA committee for 3 months and then again at 6th months to ensure the corrective action is achieved and sustained. • An in-service was given on by the Administrator to the Business office manager on the 27th of March outlining the expectations. Substantial compliance will be achieved by April 13th 2015.	

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F 160	Continued From page 2 reach the residents or the executors.	F 160		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and document review, the facility failed to ensure the confidentiality of resident clinical records when	F 164	F164 • The deficiency was noted due to failure of the employee to take a specific action when working within the electronic health record (EHR). When deficient practice was noted by the surveyor, it was brought to the attention of the offending party with immediate corrective action taken. • Theoretically, because Eskaton has an EHR, all patients could be potentially affected by the same deficient practice. Therefore, immediate inservice training was initiated during the survey to reinforce the use of the "Walk Away" task button and/or lowering of the screen to ensure the protection of the residents/patients EHR for all employee who utilize both the Point of Care system (CNAs) as well as Matrix ® (All other healthcare team members). • Confidentiality and HIPPA training is currently conducted annually for all staff. This	4-13-15

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F 164	Continued From page 3 computer screens with resident protected healthcare information were unattended and within public view. This failure had the potential to compromise the residents' right to privacy and confidentiality of protected healthcare information. Findings: During an Initial Tour on 3/10/15 at 10:10 a.m., an unattended medication cart was observed in the hallway. A laptop computer was observed on the medication cart with the monitor screen open. The resident's name, photo, diagnoses, and medications were visible on the monitor screen. In an interview with Licensed Nurse 1 (LN 1) on 3/10/15 at 10:12 a.m., LN 1 acknowledged she left the monitor screen open and unattended, which included confidential resident information. LN 1 explained and demonstrated the "Step/Walk Away" option on the computer screen. LN 1 stated she should have "clicked" on the "Step/Walk Away" icon to black-out the screen before she left the medication cart unattended. On 3/11/15 at 11:55 a.m., an unattended computer monitor was observed at a nurses' station. On the monitor display, within view from the nurses' station counter, was a resident's care conference note. In an interview with the Director of Staff Development (DSD) on 3/13/15 at 9 a.m., the DSD stated that all facility laptop and computer screens should be out of view of all staff, residents and the public, to ensure resident confidentiality.	F 164	inservice training will increase in frequency to two times a year and will incorporate specific training related to the EHR and measure to maintain confidentiality. • All staff with access to the EHR will be re-educated on the procedures for protecting the EHR no later than 04/02/2015. All department managers supervisors, and charge nurses have been trained to assist with monitoring for compliance in maintaining confidentiality and protection of the residents/patients EHR and given the directive and authority to immediately address deficient practices. Violations will escalate to a final written warning within the organizations progressive disciplinary policy. • Date of implementation of correction was 03/13/2015. Corrective action is now facility operational process that is ongoing to continue indefinitely.	

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F 164	Continued From page 4 According to a 2012 facility policy titled, "Access to Medical Records," access to resident's medical records will be limited to the staff and consultants providing service to the resident. Resident records, whether medical, financial or social in nature, are safeguarded to protect the confidentiality of the information. A 2012 facility pharmacy policy and procedure titled, "Medication Administration: General Guidelines" was reviewed. It indicated, "[A] resident's health information needs to remain private. The pages of the Medication Administration Record (MAR) must remain closed or covered when not in direct use."	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, clinical record and facility policy review the facility failed to ensure that 1 of 11 random residents (RR A) self-administered medications safely when multiple medications that were not determined by the interdisciplinary team as safe for the resident to self-administer were left at the bedside. This failure had the potential to result in infection or harm to RR A should the resident not correctly	F 176	F176 • A self-administration observation was completed for RR A on 03/11/2015, which indicated that the resident was safe for the self administration of medications. No corrective action may be made for the affected resident as the resident has discharged and medical record is closed. • All residents/patients were reviewed and discussed with the interdisciplinary team. No other residents currently self administer medications. No other residents noted to be	4-13-15

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F 176	Continued From page 5 apply or care for topical medications, miss a dose of her oral medications, take multiple doses of her oral medications at once, or choke on a pill and could potentially cause harm to a wandering resident that gained access to the unsecured medications at the bedside of RR A. Findings: RR A was admitted to the facility in 2010 with diagnoses including heart failure, hypothyroidism, urinary bladder hypertonicity, corneal dystrophy, lactose intolerance, gastroesophageal reflux, and debility. According to the most recent Annual Minimum Data Set (MDS- an assessment tool) RR A scored 15 out of 15 on the Brief Interview for Mental Status Exam (a score of 15 indicates a resident is cognitively intact). During a Medication Pass observation on 3/11/15 at 8:10 a.m., Licensed Nurse (LN) 1 prepared the following medications for administration to RR A: acetaminophen (Tylenol - a pain medication) 500 mg (milligrams - a unit of measure), lactaid (a dietary supplement for milk intolerance) 1 tab, furosemide (lasix - a water pill) 40 mg, levothyroxine (synthroid - a metabolic hormone) 25 mcg (micrograms - a unit of measure), multivitamin 1 tab, omeprazole (prilosec - a gastric acid reducer) 20 mg, oxybutynin (anticholinergic - treats urinary bladder problems), potassium chloride liquid (replace potassium lost with water pills) 10 mEq (milliequivalents - a unit of measure), and vitamin d3 (dietary supplement). LN 1 prepared the medications and 9 pills were verified in the medication cup and there was one liquid medication prepared as well. LN 1 stated RR A had her eye drops at the bedside and would self- administer them because she has a "care plan for leaving medications at	F 176	affected by this deficient practice. • The Interdisciplinary Team was re-educated to include a formal discussion on the self administration of medications during each resident care conference. Care conferences are conducted upon admission, quarterly, annually and when a significant change in condition occurs based on the Resident Assessment Instrument. The appropriateness of self administration of medications is discussed. For patients/residents expressing a desire to self administer medications a "Self-Administration of Medication Observation" will be completed. Based on the assessment and IDT determination a physician's order will be obtained to maintain medications at the bedside and a care plan developed. The team will proceed to provide a secure compartment or device for medication storage. The resident will be reassessed quarterly, annually, and with	

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F 176	Continued From page 6 the bedside." LN 1 took the prepared medications to the bedside of RR A and asked the resident if she would mind taking the pills now. RR A stated she needed to take the medications on an empty stomach and would "wait until 10:30" to take them. LN 1 then left the pills and the liquid on the bedside table of RR A and stated "she is okay - that's her norm (normal)." During an interview with the Unit Manager (UM) 2 on 3/11/15 at 8:25 a.m., she stated RR A has a self- administration care plan. UM 2 stated RR A was assessed for knowledge of each topical medication and location of administration. UM 2 stated that a Medical Doctor (MD) order would be written based on assessment. UM 2 indicated that RR A stored her "creams (topical medications)" in a drawer at her bedside. During an observation at the bedside of RR A on 3/11/15 at 8:35 a.m., a bottle labeled "artificial tears", a tube labeled "estrace" cream, and a tube labeled "proctocream/HC (hydrocortisone)" were noted in her possession. RR A stated "I keep them in the (unlocked) drawer." Review of the clinical record of RR A included a document titled Medication Self- Administration Assessment dated 1/5/15 which disclosed: "Can correctly administer eye drops or eye ointments according to proper procedure...NA...Can apply topical ointments, creams, or transdermal patches according to procedure? ...Fully Capable..Approval granted to self-administer: [both yes or no boxes are blank]." Review of the document titled IDT (Interdisciplinary Team) Conference Summary dated 1/7/15 in the record of RR A included the	F 176	significant change of condition assessment. • A QAPI tool has been created to randomly audit residents who self administer medications as well as the interdisciplinary process and continued compliance. Identified concerns will be forwarded to the Quality Assurance and Performance Improvement Committee for resolution. • Facility inservice training has been initiated and the facility will be in substantial compliance no later than April 13, 2015.	

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F 176	Continued From page 7 following notation: "Self- Administration of Medications: Inappropriate...Nurse will administer." Review of the MD orders in the clinical record of RR A included the following orders: "Apply estrace 0.01% cream to perineum and labia Q (every) night. Resident able to self administer med. May keep med at bedside...ProctoCream (hydrocortisone) cream; 2.5%; amt:-; rectal Special Instructions: Apply peri rectal. Resident able to self administer med. May keep med at bedside...matricidal tears (hypromellulose) [OTC] Drops; 0.4%; amt: 1 Drop into both eyes for corneal oystrophy [sic] and exposure TID - Three Times a Day..." There was no MD order noted in the record for self-administration of eye drops or any of the oral medications of RR A. Review of the document titled Care Plan dated 1/7/15 in the clinical record of RR A included the following problem, goal and approach: "Resident wishes to administed [sic] cream to peri/rectal area. Risk for inappropriate self administration of medication...Resident will self administer the correct cream amount to the correct areas...Resident will self administer the following creams: Estrace 0.01% cream to perineum and labia Q PM (evening) and Proctocream HC 2.5% to peri rectal BID (twice daily)." There was no care plan noted in the record for self-administration of eye drops or any of the oral medications of RR A. During an interview with the Consultant Pharmacist (Pharm D) on 3/11/15 at 1 p.m., she stated if a resident refuses oral medications (Rx) or requests later administration, the nurse takes the Rx back to the med cart and then returns with	F 176		

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F 176	Continued From page 8 Rx at the time the resident requests. She stated the nurse should not leave the Rx at the bedside with a resident to self-administer later. During a subsequent interview at 1:30 p.m. Pharm D stated RR A had self-administered all of her Rx (topical and oral) since 2012 and the documentation had not been updated." During an interview with the Director of Nurses (DON) on 3/11/15 at 4 p.m., she stated that RR A had been allowed to self-administer all of her Rx (topical and oral) "since 2012." During an interview with RR A on 3/13/15 at 8:10 a.m., she stated her "creams" and "eye drops" were now being stored in the cart. RR A stated she would like to keep her creams, eye drops, and her tylenol at her bedside because its "not always convenient for me (to ask for them)." Review of the facility policy titled Self-Administration dated 10/07 included the following pertinent parts: "Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe." Review of the facility Clinical Nursing Skills Manual published by Pearson Education in 2012 included the following Medication Safety Measure on page 579: "Do not leave any medication at the client's bedside unless there is a specific physicians order to do so." Review of the facility policy titled Medication Administration dated 12/12 included the following instructions: "Medications are to be administered at the time they are prepared...The person who	F 176		

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F 176	Continued From page 9 prepares the dose for administration is the person who administers the dose...The resident is always observed after administration to ensure that the dose was completely ingested.	F 176		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to maintain a safe homelike environment, in good repair, when: 1. When a hole in the wall was observed below the sink in resident room C 6, 2. The walls in two resident rooms, D 5-A and D 17-A, were heavily scratched and had loose and torn wall paper, and 3. A wooden dresser drawer in a resident room B 2-B, was in disrepair and had a large piece broken off exposing splinters. The failure to keep resident rooms safe, homelike and in good repair, caused residents and visitors concern and to notice. Findings: 1. During the General Observation tour of the	F 252	F252 • All of items identified (golf ball sized whole, scratched wall and dresser with exposed splinters) were repaired the same day they were identified. • Maintenance has made additional rounds throughout the building to identify any other rooms or residents that may be affected. • The Director of Environmental Services or designee will inspect all resident rooms monthly (1 wing per week) and all logs daily to ensure they are maintained properly. Staff was in-serviced (on the 3/31, 4/1 and 4/2) and reminded that any holes, chips, cracks, tares or potentially dangerous items seen in a resident area should be written in the maintenance log book. • The Director of Environmental Services or designee will report to the QA committee as outlined. Logs will be	4-13-15

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F 252	Continued From page 10 facility, accompanied by the Director of Environmental Services (DES), conducted on 3/12/15 at 10 a.m., resident room C 6 was inspected and was observed to have a large hole on the wall, right below the sink. When the DES was asked about the hole, he responded that he did not know that it was there and said that it may have been kicked by a resident. During the Initial Tour of the facility conducted on 3/10/15 at 8:30 a.m., the resident expressed in a brief interview that it bothered her seeing that hole in the wall, and that even a family member, who was a contractor, had frequently commented about it. 2. On continuation of the general observation tour, resident rooms D 5-A and D 17-A were inspected. Walls in these rooms had lose and torn wall paper with deep scratches and scrapes on the side of the walls. When the DES was questioned about the damaged walls being in need or repair, he said that the deep scrapes on the wall could have been caused by the constant raising and lowering of the beds, and/or the head of the beds. He added the scrapes could be repaired and protected by placing a plastic of metal plate on the wall. 3. Inspection of the furniture in resident room B 2-B, revealed that the wooden dresser, which was the property of the facility, had a corner of a drawer that had been broken off exposing splinters. When this potential hazard was shown to the DES, he acknowledged the splinters and said he was not made aware of it.	F 252	inspected by the committee and inspected for completed action items. This Report will be monitored by the QA committee for 3 months and then again on the 6th month to ensure that corrective action is achieved and sustained. Recommendations for continued inspections or modification will be made by the QA committee if the outcomes do not reveal improvement. • Substantial compliance will be achieved by April 13th 2015.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F281 Initial findings – Corrective actions:	4-13-15

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F 281	Continued From page 11 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, clinical record and facility policy review the facility failed to meet professional standards of quality for 3 of 24 sampled residents (4, 5, 19) and 1 random resident (RR G) when: 1) Oxygen was administered to RR G without a physician order and; 2) Two medications were ordered for pain for Resident 19 and there were no specific indications for administering one versus the other and; 3) The site of administration for two medications for Resident 4 were not specified or clarified and; 4) Medications were left unattended at the bedside of Resident 5. These failures placed residents at risk for harm due to unsafe administration of medications. Findings: 1) Resident G was admitted to the facility in February 2015 with diagnoses including atrial fibrillation (irregular heart rate and rhythm), kidney disease, anemia (decreased oxygen carrying capacity of blood), and altered mental status. During an observation and concurrent interview on 3/10/15 at 8:50 a.m., RR G was noted to have a nasal cannula (oxygen delivery device) connected to an oxygen concentrator at a flow rate of 2 liters/minute. Certified Nurse Assistant	F 281	• Resident G was discharged home. His medical record is closed therefore, no changes will be made. • Resident 19 has been transferred back to the acute; therefore no changes have been made to his medical record. • All orders for resident 4 were clarified to specify both eyes and each nares. • Resident 5 is unable to self administer medications. The licensed nurse was inserviced to not leave medications at the resident's bedside under any circumstances and to fully observe the administration and verify the ingestion of medications as ordered. Identification of other potentially affected residents: • All residents receiving oxygen were noted and staff verified to ensure that oxygen orders were in place. No other residents were affected by this deficient practice. • All PRN analgesic orders for the facility have been reviewed to ensure that each order indicates specifically when to administer the	

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F 281	Continued From page 12 (CNA) 2 verified the presence of the nasal cannula. During a concurrent interview with the Director of Nurses (DON) and clinical record review of RR G on 3/11/15 at 3:50 p.m., the DON was unable to locate a physician order for the administration of oxygen. During an interview with the Medical Records Director (MRD) on 3/13/15 at 1 p.m., MRD stated he was unable to find an order for oxygen in the clinical record of RR G. Review of the facility policy titled oxygen administration dated 6/27/11 included the following statement: "The licensed nurse will carry out the oxygen therapy orders." Review of the facility Clinical Nursing Skills book published by Pearson Education in 2012 disclosed the following on page 1182: "Procedure...1. Check physician's orders for mode of oxygen delivery and prescribed oxygen liter flow." 2) Resident 19 was admitted to the facility in March 2015 with diagnoses including chronic pain, polyarthritis (many inflamed joints), and pain in multiple joints. Review of Resident 19's document titled PRN Medication Administration History (MAH) dated 3/1/15-3/12/15 in the clinical record included the following orders; "tramadol Schedule IV tablet; 50 mg (milligram- a unit of measure); Amount to Administer: 2 TABS (100 mg) oral/ Frequency/ Every 4 hours- PRN/ Special Instructions/ FOR PAIN...Tylenol-Codeine #3	F 281	medication. Any orders noted that did not specify when to give was clarified with the physician. • All medication orders were reviewed for each resident with nasal, ophthalmic, and otic medications to ensure that the order specifies either right, left, or both. Any orders which did not specify the route was clarified with the physician. Measures put into place: • Each licensed staff nurse was provided the organizational policy for medication administration. Medications are to be administered at the time that they are prepared. The nurse will not leave any medications at the resident's/patient's bedside. • All licensed staff and unit secretaries have been educated on the order entry process and to ensure appropriate selection of routes from the "drop down menu" with the EHR. Performance monitoring • A QAPI tool has been created to randomly audit staff with for violation of the	

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F 281	Continued From page 13 (acetaminophen-codeine) Schedule III tablet; 300mg-30mg; Amount to Administer: 1 TAB oral/ Frequency/ Every 4 hours PRN/ Special Instructions FOR MODERATE TO SEVERE PAIN..." During a bedside interview with Resident 19's spouse on 3/12/15 at 1:20 p.m. while Resident 19 was sleeping, she stated Resident 19's arms hurt to the touch and were very sensitive. Resident 19's spouse stated he received tramadol for pain and tylenol #3 (medication containing a narcotic medication for pain) if the tramadol was ineffective. Resident 19's wife stated she had spoken to staff about Resident 19's pain medication. During an interview with CNA 1 on 3/12/15 at 1:50 p.m., she stated Resident 19 always complained of pain in his arms and she had to be "really gentle with him." During an interview with Licensed Nurse (LN) 2 on 3/12/15 at 1:55 p.m., he stated when Resident 19 requested pain medication he had administered tramadol every four hours at first but Resident 19 was getting really drowsy so he had switched to Tylenol #3 in the afternoon and would only give tramadol at night. During an interview with Resident 19 on 3/13/15 at 8:50 a.m., he stated "they keep telling me I am getting Tylenol # 3 with codeine [for pain]." Resident 19 denied knowledge of taking any other type of pain medication. Resident19 stated the pain medication "helps but it doesn't take care of it." During an interview with LN 3 on 3/12/15 at 9	F 281	organizational policy and standard of practice. Nurses will also be randomly observed during their medication passes to identify trends and/or patterns to be addressed through the progressive disciplinary process. The Health Information Manager (HIM) will randomly audit orders by route to ensure that all elements of the orders are appropriate as well as licensed nurses administering medications will verify all elements of the order are appropriate including the route of administration. Corrective action: • Facility inservice training has been initiated and the facility will be in substantial compliance no later than April 13, 2015.	

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F 281	Continued From page 14 a.m., he stated when Resident 19 requested pain medication he would offer him a preference of which pain medication to take, would administer whichever medication was due [if it was to early for one], or would alternate the two different medications to prevent drowsiness. During a concurrent interview and record review with Unit Manager (UM) 1 on 3/12/15 at 3:30 p.m., she verified there were no specific physician instructions in the medication orders to indicate when to give tramadol versus tylenol #3 to Resident 19. UM 1 stated that the two medications should be alternated to decrease risk of Resident 19 getting too much acetaminophen in a 24 hours period. During a concurrent interview and record review with Pharmacy Consultant (Pharm D) on 3/13/15 at 10:30 a.m., she stated "usually they alternate [the pain medications]" and "the providers orders should probably be more specific...alternate or resident choice." The Pharm D reviewed the administration history (as noted below) and verified the lack of evidence that the two medications were routinely alternated. Further review of Resident 19's PRN MAH disclosed the following documentation of medication administration: "3/1/15 11:54 a.m. tramadol..3/1/15 6:33 p.m. tramadol... 3/2/15 8:12 p.m. tylenol #3... 3/3/15 5:29 p.m. tramadol... 3/4/15 9 a.m. tramadol...3/4/15 8:18 p.m. tramadol... 3/5/15 4:39 p.m. tylenol #3... 3/6/15 1 a.m. tylenol #3...3/6/15 5:57 a.m. tylenol #3...3/6/15 1:54 p.m. tylenol #3...3/6/15 5:08 p.m.	F 281		

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F 281	Continued From page 15 tramadol... 3/7/15 2:58 a.m. tramadol...3/7/15 4:42 p.m. tylenol #3...3/7/15 8:17 p.m. tramadol... 3/8/15 8:18 a.m. tylenol #3...3.8.15 5 p.m. tylenol #3...3/8/15 10:24 p.m. tramadol... 3/9/15 1:29 p.m. tylenol #3... 3/10/15 1:07 a.m. tylenol #3..3/10/15 5:30 a.m. tramadol...3/10/15 2:33 p.m. tylenol #3...3/10/15 7:39 p.m. tramadol... 3/11/15 12:55 a.m. tylenol #3...3/11/15 1:54 p.m. tylenol #3...3/11/15 10:27 p.m. tylenol #3 3/12/15 4:14 a.m. tramadol..." Review of the document titled Care Plan dated 2/25/15 in the clinical record of R 19 included the following intervention: "MEDICATION(S) AS ORDERED." There was no entry indicating when to administer which pain medication. Review of the facility policy titled Medication Administration General Guidelines dated 12/12 included the following statement; "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices..." According to the American Society for Pain Management Nursing: "To promote patient safety and reduce medication errors, it is critical that physicians, nurses, and pharmacists share a common understanding of how to properly write, interpret, and carry out PRN range orders." Retrieved on 3/18/15 from http://www.aspmn.org/documents/RangeOrderPublished2014.pdf. Review of the facility Clinical Nursing Skills book published by Pearson Education in 2012 included the following notation under Administering	F 281		

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F 281	Continued From page 16 Medications Safely: "If a written order is illegible or is quetionable for any reason, the phsyician must be notified for clarification." 3) According to the Resident Admission Record, Resident 4 was admitted to the facility in August of 2014 with diagnoses including stroke and glaucoma (an eye disease characterized by increased pressure in the eye resulting in atrophy of the optic nerve and possible blindness). A review of Resident 4's March 2015 Physician Order Report revealed two medication orders: 1. "Latanoprost drops (antiglaucoma medication) 0.005% amount: 1 drop ophthalmic (eye) at bedtime." 2. "Dymista (a medication for seasonal allergies) spray, non-aerosol 137-50 micrograms (mcg)/spray nasal twice a day." The first order did not specify which eye(s); right, left or both, the drops should be administered. Similarly, the second order did not specify right, left or both nostrils. Resident 4's Medication Administration Record (MAR) was reviewed. "Latanoprost drops 0.005% 1 drop ophthalmic at bedtime" had been administered by licensed staff since 8/28/14, without any specification about which eye(s) required the medication. Administration of the medication "Dymista spray, non-aerosol 137-50 mcg/spray 1 spray nasal" as evidenced by the MAR, was also initiated 8/28/14 and also non-specific. According to the 2015 drug reference Lexicomp (www.crlonline.com), suggested adult dosing for Latanoprost was specific: "Ophthalmic: one drop in the affected eye(s) once daily in the evening."	F 281		

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F 281	Continued From page 17 The suggested adult dosing for Dymista was also specific: "One spray per nostril twice daily." In an interview with the Director of Staff Development (DSD) on 3/13/15 at 9 a.m., the DSD acknowledged it was a standard of nursing practice to question and clarify non-specific physician orders. The DSD stated the facility used the 8th Edition of "Clinical Nursing Skills-Basic to Advanced Skills" as a reference for clinical nursing standards of practice. A chapter titled "Medication Administration" from the facility's 8th Edition of "Clinical Nursing Skills-Basic to Advanced Skills" was reviewed. The reference indicated that "If a written order is...questionable for any reason, the physician must be notified for clarification. In many agencies, it is the pharmacist's responsibility to contact the prescriber to clarify unclear or questionable orders....Common communication breakdowns leading to medication errors include...incomplete orders." The book went on to describe "Seven Parts of Medication Orders" which included, "route of administration and any special instructions for administration...When administering medications, follow established safety rules, known as 'The Six Rights' [including]....the right method or route of administration..." A 2013 facility policy titled "Orders-Processing Recapitulation" indicated, "If an order is not able to be read, or unclear, the order will be clarified with the ordering health care provider by the nursing staff." 4) During the initial tour of the facility conducted on 3/10/15 at 9:50 a.m., the medication nurse,	F 281		

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F 281	Continued From page 18 License Nurse 1 (LN1), was observed leaving Resident 5's room and entering another room to continue passing medications. While interviewing Resident 5 in her room, a medication cup was observed on the resident's over-bed table containing multiple capsules and pills, which had been left unattended. Five minutes into the interview, the medication nurse re-entered the room and asked the resident if she had finished taking her medications. When LN 1 was asked if it was a common practice to leave medications behind unattended for the resident to take them later, she replied, "Sometimes I leave them at the bedside when she has trouble taking them. But, I return to check in on her periodically to see if she has taken them." The facility's Policy and Procedure titled, "Medication Administration General Guidelines," revised December 2012, indicates in Section 7.1 that, "Medications are to be administered at the time they are prepared." The Policy continues, "The person who prepares the dose for administration is the person who administers the dose." The book the facility uses as a clinical standard titled, "Clinical Nursing Skills," Eighth Edition, published 2012, under Medication Safety Measures, instructs the following, "Do not leave any medication at client's bedside unless there is a specific physician's order to do so." Review of the resident's medical record failed to show a physician's order allowing her medications to be left unattended at the bedside.	F 281		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328		

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F 328 SS=D	Continued From page 19 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record and document review, the facility failed to ensure 1 of 24 residents (Resident 13) received proper care and treatment of her peripherally inserted venous catheter after the administration of an antibiotic infusion. This failure left Resident 13 at risk for an occluded (formation of a blood clot) peripherally inserted catheter. Findings: During an Initial Tour of the facility on 3/10/15 at 10 a.m., Resident 13 was observed sitting up in bed. An empty 100 milliliter (ml) bag of an intravenous (IV) antibiotic was observed hanging from an IV pole to the right of her bed. The pharmacy label on the bag read, "Imipenem-Cilastatin 500 milligrams (mg). Activate and infuse intravenously every 8 hours over 60 minutes x 7 days." A handwritten note on	F 328	F328 • The peripheral intravenous catheter for Resident 13 was discontinued on 3/10/2015 (for reasons unrelated to this deficiency). • There are no other residents currently on the long term care units receiving intravenous (infusion) therapy. • The template for intravenous therapy orders has been incorporated into the EHR to eliminate dual documentation (electronic documentation by the Licensed Vocational Nurse and documentation by the Professional Registered Nurse). The Registered Nurse will now document medication infusions in the EHR, effective April 1, 2015. The Licensed Nurse that is certified in infusion therapy will observe and document tasks within the legal scope of practice of the intravenous therapy certification. Medical Records staff, as well as, Licensed staff will be educated on the process of entering the infusion orders into the EHR. • This system process change which will improve the communication and the documentation of task completion, by eliminating dual documentation. A report will be printed out each business	4-13-15

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F 328	Continued From page 20 the label was identified as well, indicating the IV antibiotic infusion was started at 8 a.m. on 3/10/15. The 100 ml bag had been infused at 100 ml/hr, as evidenced by the rate dial on the tubing, indicating the intermittent infusion finished at 9 a.m. The antibiotic bag was still connected, via tubing, to the peripherally inserted venous catheter in Resident's 13 right hand. A review of Resident 13's March Physician Orders revealed an order for "Imipenem-Cilastatin 500 mg intravenous...every 8 hours: 0000 (midnight) , 0800 (8 a.m.), and 1600 (4 p.m.)" was written on 3/9/15. Resident 13's March Medication Administration Record (MAR) was reviewed. On the MAR, Licensed Nurse 1, a licensed vocational nurse (a licensed vocational nurse is not licensed to administer IV medications), documented with her initials that she administered "Imipenem-Cilastatin 500 mg intravenous" on 3/10/15 at 8 a.m. In an interview with Licensed Nurse 3 (LN 3) on 3/11/15 at 10:25 a.m., LN 3 acknowledged she hung Resident 13's IV antibiotic on 3/10/15 at 8 a.m. LN 3 stated, as a registered nurse, she initiated the IV antibiotic and then returned to her assigned job on another unit, leaving the antibiotic in the care of the licensed nurse assigned to Resident 13. LN 3 stated the nurses "should have been keeping an eye on [the infusion]", disconnected the tubing, and flushed the catheter when it was finished. According to a 2008 facility pharmacy Infusion Therapy Policy and Procedure Manual, a policy titled, "IV Site Care and Maintenance: Flushing	F 328	day x 4 weeks and then weekly x 4 weeks to validate the efficiency, accuracy, and efficacy of process implementation. • Process implementation and education will be initiated on 4/1/2015	

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F 328	Continued From page 21 Considerations and Technique", identified the "[use of a] saline flush immediately after each dose or therapy to maintain patency and prevent drug interaction." During an interview with the Pharmacy Consultant on 3/11/15 at 12:45 p.m., she stated "the nurse should have gone by at 9 a.m. to check if [Resident 13's] IV was done."	F 328		
F 371 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to maintain the kitchen under sanitary conditions when the floor was observed to be wet, slippery and soiled with food and garbage. This failure had the potential to create an unsafe environment and could potentially lead to contamination of clean items (dishes, utensils and equipment), food preparation and/or storage. Findings:	F 371	F371 • No residents were known to be effected by the deficient practice. • All residents that eat food from the kitchen have the potential to be effected. • An in-service has been conducted by the Dietary supervisor on the importance of maintaining the kitchen in a clean and sanitary manner. This included the importance of picking up dropped packets of food like sugar, salt, pepper and syrup as well as any other substances that could cause slips, trips or falls. Dietary staff will maintain a safe amount or water on the floor in the dish room, keep anti-slip mats on the floor and be careful to ensure all food goes in the barrel when plates are being scraped. Dietary will	4-13-15

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F 371	Continued From page 22 During an Initial Tour of the kitchen on 3/10/15 at 8:55 a.m., the floor was observed to be wet and slippery. Puddles of water were identified to the right of the entrance near the dishwashing area and to the left where the tray carts were kept. The corridor running between the dishwashing area and the remainder of the kitchen was also wet and slippery. On 3/12/15 between 10:30 a.m. and 12:30 p.m., a Kitchen and Food Service Observation was performed. Upon entering the kitchen at 10:30 a.m., as lunch preparations were made, the following was observed: the floor near the entrance to the kitchen had copious amount of water puddles, sugar and/or salt packets were observed on the floor and, the dishwashing area did not have a matt (to prevent slipping). During an interview with Food Service Worker 1 (FSW 1) on 3/12/15 at 10:30 a.m. FSW 1 acknowledged the floors needed to be wiped down and was observed soaking up the water with her mop. In an interview with FSW 2 on 3/12/15 at 10:40 a.m., FSW 2 acknowledged the matt for the dishwashing area had been removed. FSW 2 stated he was at risk for slipping due to the water on the floor. Further observations of the kitchen floor revealed an area near two trash barrels and a floor drain with food crumbs and trash, such as a plastic lid from a beverage and packets of sugar/sugar substitute. The area of the floor leading to the back of the kitchen was wet with wet foot prints observed continuing toward the dry storage area. Trays of uncovered coffee cups and other clean	F 371	continue to have dietary employees wear non skid shoes and will post the 'wet floor sign' during dish washing times. If the floor appears to be 'too wet' dietary will get a dry mop head and wipe the excess water off the floors. Dietary was in-serviced on 3/31 • The Dietary supervisor will do random inspections two times per week on the cleanliness of the floor at various times throughout the day and document the inspection. This Report will be monitored by the QA committee for 3 months and then again on the 6th month to ensure the corrective action is achieved and sustained. • Substantial compliance will be achieved by the April 13th 2015	

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F 371	Continued From page 23 items were observed in this area. The floor in the back of the kitchen, where food preparation was in progress and dry bin storage was located, was observed to have food crumbs and trash. On 3/12/15 at 11:20 a.m., the plating of food from the tray line began. On one side of the tray line, the floor was observed to have food crumbs and trash (small disposable syrup or jam packet). As evidenced by a review of the March 9th through 15th 2015 resident breakfast menu, on Monday, March 9th, "pancakes with warm syrup" was served and on March 10th, 11th and 12th "buttered wheat toast" was served. In an interview with the Dietary Manager (DM) on 3/12/15 at 2 p.m., the DM explained the kitchen floor was cleaned after every meal. During a final observation of the kitchen on 3/13/15 at 11:30 a.m. during trayline, the floors were observed to be slippery with pooling water. Paper trash and food were noticed occluding the drain near the dishwashing sinks. According to a 2012 facility policy titled, "Sanitation and Cleaning," "The food service area shall be maintained in a clean and sanitary manner. All floors in the food preparation and storage areas are washable, have non-slip finish and cleaned daily."	F 371		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372	F372 • No residents are known to be affected by the deficient practice. • Transporting uncovered waste barrels within the facility is no	4-13-15

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F 372	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and document review, the facility failed to transport and/or store garbage and refuse properly. This failure had the potential to compromise sanitary conditions of the facility and invite pests. Findings: Upon Initial Tour of the facility on 3/10/15 at 9:30 a.m., a housekeeper was observed getting off the elevator pushing a gray garbage can with wheels. No lid was observed. When asked if the can contained garbage, the housekeeper answered, "Yes." On 3/11/15 at 9 a.m. an observation was made of the utility closet on B Wing in the presence of Certified Nursing Assistant 4 (CNA 4). CNA 4 unlocked the door at the back of the utility closet. Behind the door was a small closet with four gray, lined, uncovered trash cans with wheels. The trash inside each bin was observed to be in clear plastic bags, but no lids were observed. A red biohazard bin was noted in the corner of the closet with a red lid. During a concurrent observation and interview of the utility closet on C Wing with Housekeeper 1 (Hskpr 1) on 3/11/15 at 10:30 a.m., no lids were observed on the gray trash cans stored behind the locked door. Hskpr 1 stated, "[The trash cans] should have lids." Hskpr 1 explained the cans contained items like soiled "diapers", that could spread infection; lids would help prevent the spread of infection.	F 372	longer a practice and will not affect any future residents. • To reduce the risk of spreading infection, the facility will ensure that all trash transported through the facility will be cover with a lid or contained within a tied off plastic bag. This will be followed when transporting waste from a resident room and from the trash barrels to the dumpster. • The facility has in-serviced all staff on the importance of keeping trash contained in plastic or covered when transporting. The Director of Environmental services and unit managers will inspect for compliance by doing random inspections 2 x week. The DES will report to the QA committee and evaluated for effectiveness. This report will be monitored by the QA committee for 3 months and then again at 6 months to ensure the corrective action is achieved and sustained. • Substantial compliance will be achieved by the April 13th 2015	

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F 372	Continued From page 25 The Director of Environmental Services (DES) was interviewed on 3/11/15 at 10:50 a.m. The DES stated that, in the past five years, the gray garbage cans have never been covered with lids. The DES explained the gray cans were stored behind locked doors on the units and his staff spray the inside of the cans with an all purpose disinfectant that kills C. diff (a strain of bacteria) after trash was emptied from them. In an observation and interview with Hskpr 2 on 3/12/15 at 10:20 a.m., he was observed pushing a gray garbage can on wheels without a lid off the elevator and into the downstairs foyer of the facility. Hskpr 2 stated he had just emptied the trash and acknowledged the garbage can had no lid. The inside of the can was lined with a plastic trash bag. At the bottom of the can, liquid and small pieces of trash were observed. In a concurrent observation with the Dietary Manager on 3/12/15 at 12:20 p.m., one of the two dumpsters (unattended) outside the kitchen had its lid propped open with a long bar of sheet metal. The Dietary Manager was observed removing the bar of sheet metal, closing the lid, and placing the bar on the ground next to the dumpster. Despite request, the facility did not provide the Department with a policy and/or procedure regarding the transport and storage of garbage (not including the kitchen).	F 372		
F 431 SS=D	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	F 431	F431 • The nurse responsible for medication administration has been re-educated on the	4/13/15

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F 431	Continued From page 26 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, clinical record and facility policy review the facility failed to keep all medications in locked compartments for 1 of 11 random residents (RR A), when topical medications were stored in an	F 431	policy for medication administration. For RR A, medications were removed from the bedside. IDT convened and determined that resident is safe for self administration of medication. A locked box device was then installed and secured to the inside of the top drawer of the bedside table. The two keys were made for the device. One key was given to the resident and the licensed nurse has the second key on the medication pass key ring. Medication and treatment orders reviewed. Orders for self administration of medications were modified to include ophthalmic drops. • No other residents self administer medications and therefore, are not at risk for being affected by this deficient practice. • The Interdisciplinary Team was re-educated to discuss on the self administration of medications upon admission, quarterly, annually and when a significant change in condition occurs based on the Resident Assessment Instrument. The appropriateness of self administration of medications is discussed. For patients/residents expressing a desire to self administer	4-13-15.

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F 431	Continued From page 27 unlocked drawer at the bedside and 9 pills and a liquid medication were left in medications cup on a bedside table. This failure had the potential to result in infection or harm to RR A should the resident not correctly apply or care for topical medications, miss a dose of her oral medications, take multiple doses of her oral medications at once, or choke on a pill and could potentially cause harm to a wandering resident that gained access to the unsecured medications at the bedside of RR A. Findings: Random Resident A was admitted to the facility in 2010 with diagnoses including heart failure, hypothyroidism, urinary bladder hypertonicity, corneal dystrophy, lactose intolerance, gastroesophageal reflux, and debility. According to the most recent Annual Minimum Data Set (MDS- an assessment tool) RR A scored 15 out of 15 on the Brief Interview for Mental Status Exam (a score of 15 indicates a resident is cognitively intact). During a Medication Pass observation on 3/11/15 at 8:10 a.m., Licensed Nurse (LN) 1 prepared the following medications for administration to RR A: acetaminophen (Tylenol - a pain medication) 500 mg (milligrams - a unit of measure), lactaid (a dietary supplement for milk intolerance) 1 tab, furosemide (lasix - a water pill) 40 mg, levothyroxine (synthroid - a metabolic hormone) 25 mcg (micrograms - a unit of measure), multivitamin 1 tab, omeprazole (prilosec - a gastric acid reducer) 20 mg, oxybutynin (anticholinergic - treats urinary bladder problems), potassium chloride liquid (replace potassium lost with water pills) 10 mEq (milliequivalents - a unit	F 431	medications a "Self-Administration of Medication Observation" will be completed. Based on the assessment and IDT determination a physician's order will be obtained to maintain medications at the bedside and a care plan developed. The team will proceed to provide a secure compartment or device for medication storage. The resident will be reassessed quarterly, annually, and with significant change of condition assessment. • Each unit manager will maintain a list of all patients that self administer medications and perform an audit monthly of the storage of the medications that are self administered monthly x 3 months and then quarterly with the RAI instrument schedule. • Corrective in-service training was initiated on 3/12/2015.	

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F 431	Continued From page 28 of measure), and vitamin d3 (dietary supplement). LN 1 prepared the medications and 9 pills were verified in the medication cup and there was on liquid medication prepared as well. LN 1 stated RR A had her eye drops at the bedside and would self- administer them because she has a "care plan for leaving medications at the bedside." LN 1 took the prepared medications to the bedside of RR A and asked the resident if she would mind taking the pills now. RR A stated she needed to take the medications on an empty stomach and would "wait until 10:30" to take them. LN 1 then left the pills and the liquid on the bedside table of RR A and stated "she is okay - that's her norm (normal)" and then LN 1 left the room of RR A. During an interview with the Unit Manager (UM) 2 on 3/11/15 at 8:25 a.m., she stated RR A has a self- administration care plan. UM 2 stated RR A was assessed for knowledge of each topical medication and location of administration. UM 2 stated that a Medical Doctor (MD) order would be written based on assessment. UM 2 indicated that RR A stored her "creams (topical medications)" in a drawer at her bedside. During an observation at the bedside of RR A on 3/11/15 at 8:35 a.m., a bottle labeled "artificial tears", a tube labeled "estrace" cream, and a tube labeled "proctocream/HC (hydrocortisone)" were noted in her possession. RR A stated "I keep them in the (unlocked) drawer." Review of the MD orders in the clinical record of RR A included the following orders: "Apply estrace 0.01% cream to perineum and labia Q (every) night. Resident able to self administer med. May keep med at bedside...ProctoCream	F 431		

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F 431	Continued From page 29	F 431		

(hydrocortisone) cream; 2.5%; amt:-; rectal Special Instructions: Apply peri rectal. Resident able to self administer med. May keep med at bedside...matricidal tears (hypromellulose) [OTC] Drops; 0.4%; amt: 1 Drop into both eyes for corneal oystrophy and exposure TID - Three Times a Day..." There was no MD order noted in the record for self-administration of eye drops or any of the oral medications of RR A.

During an interview with the Consultant Pharmacist (Pharm D) on 3/11/5 at 1 p.m., she stated if a resident refuses oral medications (Rx) or requests later administration, the nurse takes the Rx back to the med cart and then returns with Rx at the time the resident requests. She stated the nurse should not leave the Rx at the bedside with a resident to self-administer later.

During an interview with RR A on 3/13/15 at 8:10 a.m., she stated her "creams" and "eye drops" were now being stored in the cart. RR A stated she would like to keep her creams, eye drops, and her tylenol at her bedside because its "not always convenient for me (to ask for them)."

The facility policy titled bedside medication storage dated 02/11 included the folllowing statements: "bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgement of the nursing care center's interdisciplinary resident assessment team...Bedside storage is indicated on the resident medication administration record (MAR) for the appropriate medications...permitted only when it does not present a risk to confused residents who wander into rooms of, or room

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F 431	Continued From page 30 with, residents who self-administer..the manner of storage prevents access by other residents. Locakable drawers or cabinets are required only if unlocked storage is ineffective..."	F 431	F441	
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 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	F 441	• When this deficient practice was noted during the survey, immediate corrective action was taken and all nasal cannulas for all residents receiving oxygen in the facility were changed. • All residents potentially affected by this deficient practice were identified through a visual inspection on each unit of patients/residents receiving oxygen and the nasal cannulas were changed. • A nursing order was entered into the EHR for all patients with oxygen orders for the nasal cannula to be changed on Sunday nights to facilitate documentation and accountability. This is the measure put into place that will ensure that this deficient practice does not reoccur. • Each unit manager will maintain a list of all patients actively receiving oxygen. Weekly x 4, then biweekly x 2, each unit manager will visually	4-13-15

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F 441	Continued From page 31 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, interview, and facility policy review the facility failed to ensure oxygen tubing was changed routinely when 4 of 11 Random Residents (RR) B, C, D, & G were found to have undated or outdated oxygen tubing in use. This practice could cause respiratory infections in oxygen dependent residents which could then potentially spread to other residents in the facility. Findings: 1. RR B was admitted to the facility in February 2015 with diagnoses including stroke, blood clot in the lungs, and anemia (decreased oxygen carrying capacity of the blood). During a concurrent interview and observation on 3/10/15 at 10:15 a.m., Unit Manager (UM) 2 and Certified Nurse Assistant (CNA) 3 noted RR B had a nasal cannula delivering oxygen via an oxygen concentrator at a flow rate of 2 liters (unit of measures)/minute. UM 2 and CNA 3 also verified the nasal cannula was dated 3/2/15 with black ink. 2. RR C was admitted to the facility in 2014 with diagnoses including respiratory failure, heart failure, and pneumonia. During a concurrent interview and observation on	F 441	inspect each resident on the unit for oxygen usage. The unit manager will also verify that there is an active order to administer oxygen and to change the nasal cannula on Sunday and that it was signed off as completed by the charge nurse who worked on Sunday night. A QAPI tool has been created to assist with this process. • Training has been initiated for all night shift staff and Substantial compliance will be achieved by the April 13th 2015	

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F 441	Continued From page 32 3/10/15 at 10:15 a.m., UM 2 and CNA 3 noted RR B had a nasal cannula (oxygen delivery device) at her bedside attached to an oxygen concentrator. UM 2 and CNA 3 also verified the nasal cannula was dated 3/2/15 with black ink. 3. RR D was admitted to the facility in February 2015 with diagnoses including heart failure, kidney disease, and an open wound. During a concurrent interview and observation with CNA 2 on 3/10/15 at 8:50 a.m., CNA 2 noted RR D had a nasal cannula delivering oxygen via a portable oxygen tank at a flow rate of 2 L/min. CNA 2 also verified the nasal cannula tubing had no sticker or date written on it. CNA 2 stated the sticker "fell off." 4. RR G was admitted to the facility in February 2015 with diagnoses including atrial fibrillation (irregular heart rate and rhythm), kidney disease, anemia, and altered mental status. During an observation and concurrent interview on 3/10/15 at 8:50 a.m., RR G was noted to have a nasal cannula (oxygen delivery device) connected to an oxygen concentrator at a flow rate of 2 liters/minute. Certified Nurse Assistant (CNA) 2 verified the presence of the nasal cannula and was unable to locate a sticker or date on the tubing. During an concurrent policy review and interview with the Director of Nurses (DON) on 3/10/15 at 4:30 p.m., she stated "our policy is kind of vague about changing tubing...there is some variation in dating practice among staff." The DON also stated "oxygen tubing dated 3/2/15 should have been changed on 3/9/15."	F 441		

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F 441	Continued From page 33 During a subsequent interview with the DON on 3/11/15 at 9:35 a.m., she stated facility process is oxygen tubing is usually changed weekly on Sunday night shift and one nurse missed them. The DON also indicated there was no way to verify the date tubing was changed if it was not dated. Review of the facility policy titled Oxygen Administration dated 6/27/11 included the following intervention: "...Change tubing every seven (7) days and as needed."	F 441		

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: HFEN, 29917 HFEN, 29108 HFEN, 33361 HFEN, 32476 HFEN, 33423 The facility census was 145 and the resident sample size was 24.	A 000		
A1205	T22 DIV5 CH3 ART6-72625(b) Clean Linen (b) Clean linen shall be stored in clean, ventilated closets, rooms or alcoves, used only for that purpose. This Statute is not met as evidenced by: Based on observation, interview and document review, the facility failed to store clean linen in a clean, ventilated closet, room or alcove, designated only for that purpose when three carts of clean linen were being stored in a shower room on Unit C, next to soiled linen bins (hard plastic containers). This failure had the potential for contaminating the clean linen. Findings: During the General Observation tour of the facility, accompanied by the Safety Manager and the facility's Director of Environment Services (DES), conducted on 3/12/15 at 10 a.m., the shower room on Unit C was being used to store	A1205	A1205 • No residents were affected by this deficient practice. • All residents on Codman Court had the potential to be affected. All clean linen was removed from the shower room. • Codman Court linen will now be stored in a closet dedicated for the purpose of storing clean linen only. Laundry staff will be in-serviced on the storage procedure and will only place the clean linen in the storage closet. • The housekeeping supervisor will monitor the placement of	4-13-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000071	A. BUILDING: _____ B. WING _____	C 03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER FAIR OAKS	11300 FAIR OAKS BLVD, FAIR OAKS, CA 95628

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A1205	Continued From page 1 equipment, bins of soiled linen as well as three linen carts with clean linen. All these items were stored so close to each other that the soiled linen bins were touching the clean linen carts. If anyone needed to get clean linen, they would have to roll the bins of soiled linen away from the carts, in order to reach inside and grab the clean linen. When DES and the Safety Manager were questioned about the condition of the room and the storing of clean linen, they said, "It seems a little crowded in here." When asked if they saw a problem storing clean linen carts in the shower room, the Safety Manager responded by asking, "Do you have a recommendation as to how we should store them?" The facility's policy titled, "Storage Areas," implemented on 05/01/97, addressed the storage areas in the laundry but, failed to address the importance of storing clean linen in specific areas, designated only for that purpose within the facility.	A1205	the clean linen 2 x week for one month in a random manor. The housekeeping supervisor as well as the unit manager on the Codman Court will report to the QA committee for that month on the effectiveness of the new system. Additional monitoring will be implemented if needed. • Substantial compliance will be achieved by April 13th 2015.	