PRINTED: 08/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056308	A. BUILDING _____ B. WING _____	04/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE REHABILITATION CENTER	21414 S. VERMONT AVENUE TORRANCE, CA 90502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey. Representing the Department of Public Health: [redacted], RN, HFEN [redacted] RN, HFEN [redacted] RN, HFEN [redacted] RN, HFEN Total Population: 126 Sample Size: 24	F 000	This written Plan of Correction (POC) serves as the facility's credible allegation of compliance for the deficiencies noted.	
F 248 SS=D	Highest Scope and Severity: E 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to involve one of 24 sampled residents (4) in activities according to the physician's order by failing to feed the resident in the main dining room for all three meals and to take the resident to activities daily, placing the residents at risk for decreased socialization and depression. Findings:	F 248	• Resident 4 is no longer a resident in this facility. Upon verbal notification of the alleged deficient practice, the RN Supervisor immediately reassessed resident #4. The resident was provided with daily ongoing meaningful program of activities based on his needs and individual preferences. The resident was fed according to the order of the resident's attending physician. • All other residents who are not provided with ongoing program of activities and those residents whose physician's orders are not followed are at risk to be affected by the same noted alleged deficient practice. The Activity Director and her assistants reassessed all other residents' activity needs to identify	6/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
ROY MARTINEZ	ADMINISTRATOR	8/21/12

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

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F 248	Continued From page 1 On April 20, 21, and 22, 2012, Resident 4 was observed in his room during breakfast, lunch and dinner. He was observed not leaving his room. On April 21, 2012, at 7:15 a.m. and 12:35 p.m., Resident 4 was observed sitting in his bed being fed by a certified nursing assistant (CNA). On April 21, 2012, at 12:45 p.m., during an interview, Registered Nurse (RN) Supervisor 1 stated Resident 4's white blood count was low and as a precaution, staff entering his room were directed to wear mask, gown, and gloves for his protection against infection and that was the reason why he had not left his room. On April 22, 2012, at 2:26 p.m., during an interview, the director of nursing (DON) stated she was not aware of any reason why the resident was not being taken to the dining room to eat meals but stated it was possibly due to his risk for infection. A review of Resident 4's Admission Records indicated he was admitted to the facility on April 10, 2012, with diagnoses including myeloproliferative syndrome (a group of diseases of the bone marrow), late effect of stroke with right sided hemiplegia (paralysis on one side of the body) and dysphagia (difficulty swallowing). Physician's orders for Resident 4, dated April 11, 2012, indicated the following: Feed all meals in the main dining room. No eating in bed for safety. Attend activities daily from 10 a.m. to 2 p.m.	F 248	same noted alleged deficient practice. No similar findings were noted. • The RN Supervisor will give a list of residents with orders to eat in main dining room and attend activities. And also identify residents with isolation precautions. Activity staff and licensed nurses will provide activities for each resident based on resident's comprehensive assessment and resident's interests and resident's physical, mental and psychosocial wellbeing. DON and Activity Supervisor provided training to respective departments on 4/30/12 to strongly emphasize the correction of the deficiency noted here to prevent recurrence. The training will be done monthly for the first 3 months then quarterly thereafter. • The implementation of the plan of correction will be monitored by the Activity Director and RN Supervisors through direct observation and interviews with residents and staff during their daily Quality Circle Rounds. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultants during their monthly facility visits through random direct observation, resident and staff interviews and record reviews. Significant findings will be submitted to the Administrator and shall be forwarded to the QA	
F 253	483.15(h)(2) HOUSEKEEPING &			

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F 253 SS=E	Continued From page 2 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility's maintenance and housekeeping staff failed to ensure the residents' environment was maintained in a sanitary, safe, and orderly manner. This deficient practice does not promote quality of life for the residents. Findings: a. On April 20, 2012, at 4:30 p.m., during the initial tour of the facility and throughout the remainder of the survey, the following were observed: 1. In Room 17 Bed A, the light bulb over the resident's bed was out. The resident's privacy curtain was stained and there was a hole in the wall behind the resident's bed. 2. In Room 64 Bed C, the paint on the wall next to the bed was missing. 3. In Room 10, the floor was sticky and the screen on the patio door was torn. 4. In Rooms 9 and 17, the closet door would not close. 5. In Room 39, peeling paint was observed on the wall near the window. On April 20, 2012, at 5:30 p.m., during an	F 253	Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12. • a. Upon verbal notification of the alleged deficient practice; 1. Room 17A light bulb and privacy curtain was replaced and hole in wall behind resident bed was fixed on 4/27/12. 2. Room 64C wall was painted on 4/30/12. 3. Room 10 floor was waxed and patio door screen was fixed on 4/23/12. 4. Room 9 and 17 closet doors were fixed on 4/23/12. 5. Room 39 wall near window was painted on 4/25/12. b. Upon verbal notification of the alleged deficient practice; 1. Room 31 bathroom floor tiles were replaced on 4/27/12. 2. Shower room floor tiles were replaced on 4/28/12. 3. Room 64 window screen was replaced on 4/22/12. 4. Room 23 closet door hinges were replaced on 4/23/12. 5. Room 70 bathroom fixture cover is changed and floor tile and hole were repaired on 4/24/12. 6. Cracked line on Room 24, 26, 27	6/1/12

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F 253	Continued From page 3 interview, Licensed Vocational Nurse 3 stated she would take care of the issues. b. During a general observation of the facility on 4/21/12 at 2 p.m., the following were observed: 1. One of the bathroom floor tiles in Room 31 was half cracked. 2. The shower room next to the main dining room had 2 cracked floor tiles. 3. The window screen in Room 64 was dented. 4. The closet door hinges in Room 23 had hinges coming off the wood. 5. The bathroom light bulb in Room 70 had no fixture cover. There was also a missing floor tile and a hole found in the bathroom. 6. The cement plaster between the bathroom wall and sink of Rooms 24, 26, and 27 had big cracked line. 7. The wood bench/table located at the front patio was broken and falling apart. 8. The faucet in Room 25's bathroom had rust and a hole at the base area. 9. The wheelchairs' left and right arm rest upholsteries for Room 38 B, 30 C, 20 A, 23 A, and 28 B, were torn.	F 253	was fixed on 4/24/12 7. Wood bench was removed and trashed on 4/21/12. 8. Room 25 faucet was replaced on 4/22/12. 9. The wheelchair armrests for Room 38B, 30C, 20A, 23A, and 28B were all replaced on 4/23/12. • All other residents are at risk to be affected by the same noted alleged deficient practice. The Physical Environment Supervisor reassessed all other resident rooms and equipments to identify same alleged deficient practice. No similar findings were identified. • The PES along with his assistant will conduct weekly sweeps of the facility to assess and identify concerns and to ensure that residents' environment is maintained in a sanitary, safe and orderly manner. • The implementation of the plan of correction will be monitored by the PES and Department Heads during their daily Quality Circle Rounds. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random direct observation during scheduled monthly facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for	
F 281 SS=D	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 observation, interview, and record review, the facility's nursing staff failed to obtain a blood pressure for one of 24 sampled residents			

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F 281	Continued From page 4 (19), using a correct method. Resident 19's blood pressure was taken with the blood pressure cuff applied over a thick jacket, placing the resident at risk for incorrect blood pressure readings, which could lead to inappropriate medication management. Findings: On April 22, 2012, at 9:48 a.m., Licensed Vocational Nurse (LVN) 4 was observed during medication pass. LVN 4 took Resident 19's blood pressure by placing the blood pressure cuff over a thick jacket that the resident wore. The resident's blood pressure reading was 118/56 millimeter mercury (mmHg). On April 22, 2012, at 10:45 a.m., LVN 4 acknowledged, after it was brought to her attention, that taking blood pressure over thick clothing could possibly alter the results of the reading, and if the clothing was able to be removed then it should be removed. A review of Resident 19's Admission Records indicated she was readmitted to the facility on November 29, 2008, with a diagnosis of hypertension. Physician's Orders, dated November 29, 2008, indicated Resident 19 was to receive amlodipine besylate (treats hypertension) 5 milligrams (mg) daily and to hold medication for systolic blood pressure (the top number in a blood pressure reading) below 110 mmHg. According to About.Com "High Blood Pressure", Proper Technique for Blood Pressure Monitoring"	F 281	trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12. • Upon verbal notification of the alleged deficient practice, Resident 19 was immediately assessed by the DON. The involved licensed nurse was provided training by the DON on 4/24/12 on how to properly obtain blood pressure readings. The resident is closely monitored to ensure that the resident's blood pressure is taken properly and correctly. • All other residents are at risk to be affected by the same noted alleged deficient practice. The DON along with Pharmacy Consultant provided training on 4/25/12 to all licensed nurses on the Proper Technique for Blood Pressure Monitoring. Skills competency was done to evaluate staff's performance to ensure that the deficient practice does not recur. • The DON and DSD will conduct skills proficiency training for nursing personnel monthly for the first 3 months then quarterly thereafter. Continuation on Page 5A of 34	6/1/12

F 281	This is to ensure that services provided by nurses meet professional standards of quality. Random return demonstration will be conducted during ADL cares and daily performance of nursing procedures. Performance evaluation will be done yearly. • The implementation of the plan of correction will be monitored by the DSD and RN Supervisors through evaluation of staff's performance during cares and treatment. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant during her scheduled facility visits through random review of the Skills Proficiency Checklist validated by random direct observation of staff's performance. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	

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F 281	Continued From page 5 From Craig Weber, M.D., updated February 5, 2007. Blood pressure should be measured while you are seated comfortably. The arm being used should be relaxed, uncovered, and supported at the level of the heart.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to provide the necessary care and services for two of 24 sampled residents (4, 5) and one randomly selected (RS 1) resident. The nursing staff failed to apply A and D ointment to Resident 4's left knee and left foot plantar (sole) according to physician's order. They failed to identify, monitor, and followed up on the status of Resident 5's reddened eyes with discharge. They failed to clarify physician's order for nutritional supplement for RS 1. RS 1's physician's order for Prostat (nutritional supplement for wound healing) did not specify what type. These deficient practices had the potential to cause delay in treatment and/or worsening of residents' condition. Findings:	F 309	• a) Resident 4 is no longer a resident of the facility. Upon verbal notification of the alleged deficient practice, Resident 4 was immediately visited by the RN Supervisor. The involved LVN applied the A&D ointment on resident 4's left knee and left foot plantar (sole). The resident was closely monitored to ensure that the resident receive the treatment as ordered. b) Upon verbal notification of the alleged deficient practice, Resident 5 was immediately visited by the RN Supervisor. The resident's eyes were assessed and are closely monitored by the charge nurses daily. The MD was immediately notified with orders for treatment in both eyes. c) RS1 is no longer a resident of the facility. Upon verbal notification of the alleged deficient practice, the order for the nutritional supplement for RS 1 was clarified with the resident's physician. The RS1 received ProStat 64 and was closely monitored. • All other residents whose physician orders are not followed, whose medical condition are not assessed, monitored and followed through and	6/1/12

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F 309	Continued From page 6 a. On April 21, 2012, at 11:51 a.m., during a treatment observation, Licensed Vocational Nurse (LVN) 5 neglected to apply vitamin A and D ointment to Resident 4's left knee and left foot. On April 22, 2012, at 2:38 p.m., during an interview, LVN 5 stated she must have overlooked the treatment order for Resident 4's left knee and foot. A review of Resident 4's Admission Records indicated he was admitted to the facility on April 10, 2012. Physician's Orders, dated April 10, 2012, indicated to apply vitamin A and D ointment to Resident 4's left knee for dry reddish granulation tissue and to the resident's left foot plantar for dry flaky skin. b. On April 21, 2012, at 7:30 a.m., 9:00 a.m., 10:25 a.m., and 2:15 p.m., and on April 22, 2012, at 9:15 a.m., and 1:20 p.m., Resident 5 was observed to have redness and discharge from both of her eyes. On April 22, 2012, at 1:25 p.m., during an observation and interview, LVN 6, after inspecting Resident 5's eyes, stated she had not noticed the redness and discharge from the resident's eyes. A review of Resident 5's Medical Records found no written documentation the redness and discharge from the resident's eyes had been assessed, monitored, and followed up. The Admission Records indicated she was readmitted to the facility on October 29, 2010, with diagnoses including dementia (loss of mental	F 309	residents with unclear physician's orders are at risk to be affected by the same noted alleged deficient practice. The RN Supervisors assessed residents with changes in conditions and those that require treatment, and reviewed the physician's orders for clarity and accuracy to identify same noted alleged deficient practice. No similar deficient practice was noted. • The DON provided training to licensed nurses on 5/2/12 on the Provision of Necessary Care and Services to all residents to ensure that a resident attain or maintain his or her highest practicable physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care. The training strongly emphasized the correction of the deficiencies noted here to prevent recurrence. The training will be done monthly for the first 3 months then quarterly thereafter. • The DON and RN Supervisor will monitor the implementation of the plan of correction through direct observation and evaluation of staff's performance during cares and treatment daily during their Quality Circle Rounds daily. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random observation of staff performance and validated by interviews and record reviews during her scheduled monthly	

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F 309	Continued From page 7 abilities). The Minimum Data Set (MDS), an assessment and care screening tool, dated April 11, 2012, indicated Resident 5 was cognitively impaired and was totally dependent on the facility's staff for her activities of daily living. c. During the 9 a.m. medication pass on April 22, 2012, Licensed Vocational Nurse (LVN) 2 administered 30 cubic centimeters (cc) of Prostat 101 to RS 1. During an interview and record review with LVN 2, on April 22, 2012 at 10:30 a.m., he said Prostat 101 is for non-diabetic residents and Prostat 64 was for diabetic residents, however he was not able to explain why there was no specific dosage indicated on the physician's order. The clinical record for RS 1 was reviewed on April 22, 2012 at 10:20 a.m. The resident was admitted to the facility on March 16, 2012, with diagnoses that included pressure sore (areas of damaged skin caused by staying in one position for too long). A review of the physician's order, dated March 16, 2012, indicated Prostat 30 cc twice daily, there was no specific indication what type of Prostat to be given 101 or 64. A review of the Medication Sheet for March 2012, indicated the licensed nurses documented Prostat 30 cc twice daily from March 17 to 31, 2012, without indication what type was given to RS 1, 101 or 64. According to http://www.pro-stat.com/pro-stat_faqs.asp by the	F 309	facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	

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F 309	Continued From page 8 Medical Nutrition USA, Inc, Pro-Stat 64 has 15 grams of protein and 60 calories per 30 ml (one ounce). Pro-Stat 101 has 15 grams of protein per 30 ml (one ounce) and 101 calories per 30 ml. The additional calories per dose in Pro-Stat 101 come from 10.2 grams of fructose. Pro-Stat 64 is sweetened with sucralose (SPLENDA No Calorie Sweetener), which is non-nutritive.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure a bed bath for one of 24 sampled residents (5) included complete cleaning of the body and the perineal area (the region below the pelvis and between the upper thighs). Failure to conduct a thorough bed bath places residents at risk for mal odor of the body, skin breakdown and uncleanliness. Findings: On April 22, 2012, at 9:15 a.m., Resident 5 was observed during her bed bath. Certified Nursing Assistant 4 (CNA 4) neglected to wash the resident's hands, inside and behind her ears, her chest, and between her toes. The resident's perineal area was not opened for thorough	F 312	• Upon verbal notification of the alleged deficient practice, Resident 5 was visited by the RN Supervisor. The resident was immediately provided with a complete bed bath that included complete cleaning of the resident's body and perineal area. The involved CNA was provided one-on-one training by the DSD on provision of necessary services to maintain good grooming and hygiene. The resident is now closely monitored by the Charge Nurses to prevent recurrence of the alleged deficient practice. • All other resident who are not provided with necessary care and service to maintain good grooming and personal and oral hygiene are at risk to be affected by the same noted alleged deficient practice. The DSD and RN Supervisor conducted a random observation during ADL cares to identify same noted alleged deficient practice. No similar findings were noted. • The DSD will conduct Skills	6/1/12

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F 312	Continued From page 9 cleaning. On April 22, 2012, at 1:10 p.m., during an interview, CNA 4 stated he was nervous and that may have been why he did not clean the resident completely. A review of Resident 5's Admission Records indicated she was readmitted to the facility on October 29, 2010, with diagnoses of clostridium difficile (bacteria causing diarrhea) and dementia (loss of mental abilities). According to a Minimum Data Set (MDS), an assessment and care screening tool, dated April 11, 2012, indicated Resident 5's cognitive skills for daily decision-making were severely impaired. She required extensive assistance with personal hygiene and bathing and was assessed with a functional limitation in range of motion (ROM) to her upper and lower extremities. A facility policy on Perineal Care, not dated, indicated the purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Wash the perineal area, wiping from front to back. Separate the labia and wash the area downward from front to back.	F 312	Proficiency and Competency training for direct care staff to evaluate staff's performance in providing necessary care and services to each resident to maintain good grooming and personal and oral hygiene. The DON and DSD provided in-service to nursing staff on 5/29/12 on ADL care including complete cleaning of the body and perineal area. The training will be done monthly for the first 3 months then quarterly thereafter. • The implementation of the plan of correction will be monitored by the DSD and RN Supervisors through direct observation and evaluation of staff's performance during ADL cares. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random review of the skills competency checklist validated by direct observation during ADL cares. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure three of 24 sampled residents (5, 7, 13), who had pressure sores (areas of damaged skin caused by staying in one position for too long) and/or were at high risk for developing pressure ulcers, were turned every two hours in accordance with the residents' plans of care. This deficient practice placed the residents at risk for development of new skin break down and/or non-healing of existing pressure sores. Findings: 1. On April 21, 2012 at 2:30 p.m. and 5:30 p.m., for a total of three hours, Resident 7 was observed lying on his right side. The clinical record for Resident 7 was reviewed on April 21, 2012. The Admission Face Sheet indicated the resident was admitted to the facility on January 21, 2012. A review of the MDS, dated February 2, 2012, indicated Resident 7's cognitive status was severely impaired, and the resident was totally dependent on staff for activities of daily living and bed mobility. A review of the plan of care addressing Resident	F 314	• 1) Resident 7 is no longer a resident at the facility. Upon verbal notification of the alleged deficient practice, Resident 7 was immediately repositioned on his left side. The resident was closely monitored by the charge nurse to ensure that the resident was repositioned every 2 hours. 2) Upon verbal notification of the alleged deficient practice, resident 13 was immediately repositioned and was reassessed by the RN Supervisor and the treatment nurse. The skin assessment documents the resident's skin condition accurately. The resident is closely monitored by the RN Supervisors to ensure that the resident is repositioned timely and the skin assessment is documented accurately. 3a) and 3b) Upon verbal notification of the alleged deficient practice, resident 5 was immediately repositioned with adequate repositioning devices to maintain the desired position which include the use of repositioning devices. The resident is closely monitored by the licensed nurses at least every 2 hours to ensure that the resident is repositioned properly with the use of repositioning devices to maintain the desired position.	6/1/12

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F 314	Continued From page 11 7's Stage III (full thickness skin loss involving damage to or necrosis [tissue death] of subcutaneous tissue [the third of the three layers of skin]) right buttock pressure sore, dated February 13, 2012, indicated staff would reposition the resident every two hours. The care plan addressing the resident's Stage II left buttock pressure sore, dated April 6, 2012, indicated the staff would reposition the resident every two hours. Another care plan, dated February 22, 2012, addressing the resident's Stage III coccyx (lower back) pressure sore, indicated the facility staff would reposition the resident every two hours. The care plan, dated March 24, 2012, addressing the resident's Stage 1 (intact skin with persistent redness) left hip pressure sore, indicated the staff would reposition the resident every two hours. These were not implemented. On April 22, 2012 at 2:30 p.m., during an interview, CNA 6 stated Resident 7 was on turning schedule every two hours. The undated facility policy and procedure titled, "Repositioning," indicated repositioning is critical for a resident dependent upon staff for repositioning. The policy further indicated residents who are in bed should be on an every two hour turning program, and for those residents with a stage 1 or above pressure sore, every two hour turning is inadequate. 2. The clinical record disclosed Resident 13 was re-admitted to the facility on 5/1/11 with diagnoses that included pressure sore Stage II (partial thickness skin loss involving epidermis, dermis, or both [top layers of the skin]) and	F 314	• All other residents who are not properly repositioned timely and those not provided devices and equipment to maintain desired positions are at risk to be affected by the same noted alleged deficient practice. The RN Supervisors conducted inspection across all shifts to identify same noted alleged deficient practice. No similar findings were observed. • The DSD together with Wound Consultant provided training to direct caregivers on 4/30/12 on the Provision of Necessary Treatment and Services to residents with existing pressure sores and to residents assessed as at risk to develop pressure sores to prevent development of pressure sores and to promote healing. The training strongly emphasized Pressure Sore Prevention with Proper and Timely Repositioning with the use of repositioning devices or equipments and on the correction of the deficiencies noted here. The training will be done monthly for the first 3 months the quarterly thereafter. The staff's performance will be periodically evaluated by the DSD. • The implementation of the plan of correction will be monitored by the DSD and licensed nurses through direct observation of staff performance and staff interview	

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F 314	Continued From page 12 hemiplegia (paralysis of one side of the body). A review of Resident 13's Minimum Data Set (MDS), an assessment and care screening tool, dated 2/11/12 indicated the resident was severely impaired with cognitive skills (mental ability) for daily decision making and was totally dependent on the staff with bed mobility (moving from side to side while in bed), with transfer (to move from one place to another), and toilet use. The resident was incontinent of bladder and bowel. There was a physician's order, dated 3/13/12, to cleanse Resident 13's left and right buttocks multiple scratches with soap and water, pat to dry and apply butt paste twice daily. A review of the Nursing Progress Notes, dated 3/16/12 at 11 p.m., indicated Resident 13 was noted to have right and left buttocks multiple scratches and wound treatment was provided as ordered. A review of the Weekly Summary Nurses Progress Notes, dated 3/20/12, 3/27/12, 4/13/12, 4/10/12, and 4/17/12 indicated Resident 13 was assessed having existing multiple scratches on her left and right buttocks. A review of the Pressure Ulcer Record, dated 3/13/12, 3/20/12, 3/27/12, 4/10/12, 4/13/12, and 4/17/12 indicated Resident 13 had Stage II pressure sores on her left and right buttocks. On 4/20/12 at 4:15 p.m., 5 p.m., 6 p.m., and 8 p.m., for more than three hours, Resident 13 was observed in bed, lying on her right side and was not turned.	F 314	during ADL cares and during their Quality Circle Rounds. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random review of the Competency Checklist validated by random direct observation and evaluation of staff performance. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	

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F 314	Continued From page 13 During an interview with Certified Nursing Assistant (CNA) 1 on 4/20/12 at 8:30 p.m., she stated she was so busy attending another resident that she forgot to turn Resident 13 every 2 hours. On 4/21/12 at 12 p.m., during a wound care observation with Licensed Vocational Nurse (LVN) 1, Resident 13 was observed with a Stage II right buttocks pressure sore measuring 1.3 cm (centimeters) in length by 1 cm in width. During an interview with LVN 2 on 4/21/12 at 2 p.m., she agreed the licensed nurses were doing an incorrect assessment of Resident 13's skin condition. A review of Resident 13's care plan, dated 3/13/12, for Stage II pressure sore on the left and right buttocks interventions included for the licensed nurses to reposition the resident at least every 2 hours and to keep the area clean and dry. A review of the facility's policy and procedure for Pressure Ulcer Management dated 9/7/11 indicated to prevent further skin breakdown, staff must ensure residents are turned and repositioned in bed or chair, and skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3a. On April 21, 2012, at 9:05 a.m., during a wound treatment observation, Resident 5 was observed with excoriation (superficial skin loss) and redness to her buttocks. On April 21, 2012, at 9:50 a.m., 10:25 a.m., 10:40	F 314		

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F 314	Continued From page 14 a.m., 12:10 p.m., 2:15 p.m., and 4:15 p.m., for a total of six hours and on April 22, 2012, at 6:55 a.m., and 9 a.m., Resident 5 was observed lying in bed, on her back. At times, the resident ' s upper body was positioned slightly turned to the right or left, however her buttocks and feet were pressing on the mattress. On April 22, 2010, at 1:15 p.m., during an interview, CNA 4 stated he turned Resident 5 every two hours but may have to use pillows to make sure she is completely off of her back. A review of Resident 5's Admission Records indicated she was readmitted to the facility on October 29, 2010, with diagnosis of dementia (loss of mental abilities) and pressure ulcer on her buttocks. According to the MDS assessment, dated April 11, 2012, Resident 5 was totally dependent on the facility's staff with a two + person assist for bed mobility. Another MDS assessment, dated January 3, 2012, indicated Resident 5 was assessed with Stage 1 and Stage II pressure ulcers. 3b. On April 21, 2012, at 9:05 a.m., during the wound treatment observation, LVN 6 uncovered Resident 5's legs and were observed with pillows under them however, the resident's right medial (inside) heel was observed to be pressing on the mattress. Upon closer examination of the resident's right heel, it was observed to have a large, silver dollar size reddened area. When LVN 6 completed Resident 5's wound treatment, she placed pillows under the resident's legs; however her right heel remained pressing on the	F 314		

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F 314	Continued From page 15 mattress. On April 22, 2012, at 9:15 a.m., during Resident 5's bed bath, CNA 4 removed the covers from the resident's legs to clean her legs and feet. The resident's legs were observed with pillows under them but her heels were pressing on the mattress. Observation of the resident's heels showed redness. On April 2, 2012, at 1:15 p.m., during an interview, CNA 4 stated floating heels while in the bed meant the resident's heels should not touch the mattress to keep pressure off of them. According to the Braden Scale for Predicting Pressure Sore Risk, dated April 11, 2012, Resident 5 was identified high risk for developing pressure sores. Physician's Orders, dated November 30, 2011, indicated to float both Resident 5's heels while in the bed. This was not followed.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	• a) Upon verbal notification of the alleged deficient practice, Resident 5 was assessed by the RN Supervisor. The resident was immediately provided proper indwelling catheter care and monitored for signs of infection. The assigned licensed nurse was apprised by the RN Supervisor of the alleged deficient practice and was provided one-on-one training by the DSD on 4/27/12 on the Provisions of Foley Catheter Care properly. The resident is closely monitored by the treatment	6/1/12

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F 315	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's staff failed to provide proper indwelling urinary catheter (tube used to drain urine from the bladder) care for two of 14 sampled residents (Resident 5 and 7), which had the potential to cause urinary tract infections (infections of the urinary bladder). Findings: a. On April 21, 2012, at 8:45 a.m., Licensed Vocational Nurse (LVN) 6 treated Resident 5's wound but did not look at or clean her indwelling catheter. On April 22, 2012, at 9:15 a.m., during Resident 5's bed bath, Certified Nursing Assistant (CNA) 4 cleaned the resident by wiping the top of her perineal area (the region of the body below the pelvis and between the thighs). CNA 4 did not clean the resident's indwelling urinary catheter. On April 22, 2012, at 1:10 p.m., during an interview, CNA 4 stated he had not been instructed to do indwelling unrinary catheter care for residents with catheters. On April 22, 2012, at 1:25 p.m., during an interview, LVN 6 stated it was the treatment nurses' responsibility to do indwelling urinary catheter care, which included checking for skin redness, excoriation (superficial skin loss), wetness, leakage, odor, sediments and color of urine. She stated it was her responsibility to clean the indwelling urinary catheter. LVN 6 acknowledged she had not done indwelling	F 315	nurses to ensure that the resident receives proper Foley catheter care daily. b) Resident 7 is no longer a resident at the facility. Upon verbal notification of the alleged deficient practice, resident 7 was assessed by the RN Supervisor. The resident was immediately provided proper indwelling catheter care and closely monitored for any signs of infection. The assigned licensed nurse was apprised by the RN Supervisor of the alleged deficient practice and was provided one-on-one training by the DON on 4/23/12 on the Provisions of Foley Catheter Care and Perineal Care. The resident is closely monitored by the treatment nurses to ensure that the resident receives proper Foley catheter care daily. * All other residents who are not provided proper Foley catheter care are at risk to be affected by the same noted alleged deficient practice. The RN Supervisors and the treatment nurses visited all residents with Foley catheters to identify same alleged deficient practice. No similar findings were noted. * The facility has a Urinary Catheter Management System. This system provides clear guidelines on how to	

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F 315	Continued From page 17 urinary catheter care with Resident 5. A review of Resident 5's Admission Records indicated she was readmitted to the facility on October 29, 2010, with diagnoses including clostridium difficile (a bacterium that causes diarrhea) and dementia (loss of mental abilities). According to the Minimum Data Set (MDS), an assessment and care screening tool, dated April 11, 2012, Resident 5's cognitive skills (mental ability) for daily decision-making were severely impaired. She was totally dependent on the nursing staff for personal hygiene and bathing and was assessed with functional limitation in range of motion (ROM) to her upper extremities, was incontinent of bowel functions and had an indwelling urinary catheter. Physician's Orders, dated October 29, 2010, indicated to do indwelling catheter care to Resident 5's indwelling urinary catheter daily. This was not followed. b. On April 21, 2012 at 9:25 a.m., CNA 5 was observed wiping Resident 7's indwelling catheter with a wash cloth using an upward (toward the resident) and downward (away from the resident) motion. During an interview, on April 21, 2012 at 1:45 p.m., CNA 5 stated he does indwelling urinary catheter care by wiping the catheter using downward motion. When asked about the observed procedure, wiping the catheter using upward and downward motion, CNA 5 stated he was folding the washcloth.	F 315	perform proper Foley catheter care. A Foley catheter care procedure is in place and is being implemented. Training on the established system was provided to reinforce the P&P by the DON and DSD to licensed nurses on 5/29/12 and will continue monthly for the first 3 months then quarterly thereafter. • The implementation of the plan of correction will be monitored by the RN Supervisors and DSD through direct observation during Foley catheter care across all shifts. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant during her scheduled facility visits through random direct observation and evaluation of staff's performance when rendering Foley catheter care. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	

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F 315	Continued From page 18 The clinical record for Resident 7 was reviewed on April 21, 2012. The Admission Face Sheet indicated the resident was admitted to the facility on January 21, 2012, with a diagnosis of urinary tract infection. A review of a physician's order dated January 21, 2012, indicated for the resident to receive indwelling urinary catheter care daily. On April 22, 2012 at 1:45 p.m., the director of nursing (DON) stated indwelling urinary catheter care is to be done by licensed nursing staff.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure one of 24 residents (19) joints were completely ranged or moved to its full potential during range of motion (ROM) exercises, placing the resident at risk for development of contractures. Findings: On April 22, 2012, at 8:45 a.m., Resident 19 was observed in her room sitting in a wheelchair.	F 318	• Upon verbal notification of the alleged deficient practice, resident 19 was visited by the Physical Therapist and the involved RNA. The Physical Therapist apprised the RNA of the alleged deficient practice and the Physical Therapist provided all RNAs with training on 4/26/12 on how to conduct complete and proper range of motion exercises to the resident. The resident is closely monitored to ensure that the resident is provided with the proper range of motion exercises to prevent functional decline of range of motion. • All other residents who do not receive proper and adequate range of motion exercises are at risk to be affected by the same noted alleged deficient practice. The DSD and some of the rehabilitation personnel conducted direct observation of RNA's performance in rendering range of motion exercises to residents to identify same alleged deficient practice. No similar findings were noted. • The Director of Rehab Services provided in-service on 4/26/12 to all RNAs on appropriate environment for residents with limited ROM for effective ROM exercises. The	6/1/12

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F 318	Continued From page 19 Restorative Nursing Assistant (RNA) 1 attempted to provide ROM exercises to the resident's lower extremities while the resident was sitting in her wheelchair. RNA 1 was not able to stretch the resident's left and right hip joints while doing abduction (away from the body) stretches because the armrest of the wheelchair would not allow full range of motion. In addition, the wheelchair's wheel would not lock and the wheelchair would roll every time RNA 1 attempted to abduct the resident's lower extremities. On April 22, 2012, at 1:57 p.m., during an interview, RNA 1 acknowledged ROM exercises are best done when the resident is in bed because she can then fully stretch the joints of the lower extremities. She stated she tried to lock Resident 19's wheelchair but it would not lock. A review of Resident 19's Admission Records indicated she was readmitted to the facility on November 29, 2008, with a diagnosis of altered mental status. Physician's Orders, dated November 29, 2011, indicated Resident 19 was to receive active assisted ROM exercises (the resident performs the exercise but requires some help) to both of her lower extremities seven days a week, daily, as tolerated.	F 318	facility's Restorative Nursing Management System was reviewed and necessary revisions were made with regard to Provision of Range of Motion exercises to the residents accurately. The Physical and Occupational therapists will provide training to nursing personnel on Range of Motion exercises with strong emphases on the correction of the deficiency noted here. The training will be done monthly for the first 3 months then quarterly thereafter. A Skills Proficiency and Competency Evaluation will be done at least quarterly. • The implementation of the plan of correction will be monitored by the DSD through random direct observation and evaluation of the staff's performance when rendering ROM exercises to residents. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant by reviewing the Skills Competency Evaluation validated by random direct observation of staff's performance during her scheduled facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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F 323	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure the safety of four of 24 sampled residents (4, 5, and 11). Resident 4, who had dysphagia (difficulty swallowing), was fed in his bed despite a physician's order to feed the resident with all three meals in the dining room for safety. This deficient practice had the potential to cause aspiration (foreign materials [usually food, liquids, vomit, or fluids from the mouth] are breathed into the lungs). Resident 5, who had the habit of rubbing and scratching her face, nose, and eyes, had fingernails that were not maintained at a safe length. This deficient practice had the potential to cause skin tears and potential eye injury. Resident 11, when he held onto a rolling television cart, caused him to fall against the side rails of the bed sustaining a laceration to his right forearm. The facility failed to secure televisions placed on top of the table. Some tables wobbled when touched and/or were on rollers. The facility failed to ensure items on top of the shelves (affixed to the walls) were secured. This practice had the potential for the television and items to fall and hit the residents causing injuries.	F 323	* a) Upon verbal notification of the alleged deficient practice, resident 5's fingernails were trimmed and filed. The resident's behavior habit of pulling and twisting her hair, scratching her face, nose and eyes area was assessed by the RN Supervisor. A plan of care was developed and is implemented to prevent and reduce the risk for injury. The resident is closely monitored. b) Upon verbal notification of the alleged deficient practice, the observed miscellaneous items on the shelves in room 17 and 20 were properly secured by the Physical Environment Supervisor. The observed television on top of table/carts in rooms 9, 10, 12, 14, 16, 18 and 68 are now properly secured. The wheels of the carts are provided with locks to prevent from wobbling when touched. c) Resident 4 is no longer a resident at the facility. Upon verbal notification of the alleged deficient practice, resident 4 was immediately assessed by the RN Supervisor. The resident was being fed sitting up in a chair during all meals. The resident was assisted and closely monitored for signs and symptoms of aspiration during meals.	6/1/12

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F 323	Continued From page 21 Findings: a. On April 21, 2012, at 9:05 a.m., 7:30 a.m., 8:40 a.m., 9:05 a.m., 10:25 a.m., 10:40 a.m., and 2:15 p.m. and on April 22, 2012, at 6:55 a.m., and 9:15 a.m., Resident 5 was observed using her left hand to pull and twist her hair, scratch her face, nose, and eye area. Red lines could be seen in the creases of the resident's nose. The resident's fingernails were observed to be long for the resident with this kind of behavior. On April 22, 2012, at 1:25 p.m., during an interview, Licensed Vocational Nurse (LVN) 6 stated it was Resident 5's habit of fidgeting, pulling her hair and rubbing her face with her left hand. LVN 6 stated she had not thought about the resident's fingernails possibly causing injury to her skin or eyes. A review of Resident 5's Admission Records indicated she was readmitted to the facility on October 29, 2010, with a diagnosis of dementia (loss of mental abilities). According to the Minimum Data Set (MDS), an assessment and care screening tool, dated April 11, 2012, indicated Resident 5's cognitive skills (mental capability) for daily decision-making were severely impaired and she required extensive assistance for personal hygiene. b. On April 20, 2012, at 4:30 p.m., during the initial tour of the facility, in Rooms 17 and 20, the shelves attached to the walls observed to have multiple miscellaneous items including a water filled vase and a tape player on top and were not	F 323	d) Upon verbal notification of the alleged deficient practice, the observed TV set that was placed on top of the TV cart for resident 11 was immediately secured and the wheels of the TV cart was locked. The facility staff was instructed to always lock the wheels of the TV cart to keep it steady to prevent and/or decrease risk of accident or injury. There is a written care plan to resident's propensity for accidents that includes but not limited to the risk factors or possible cause factors, how the resident is being monitored to reduce risks for accidents and prevent injury. • All other residents whose environment is not free of accident, hazards and those residents who do not receive adequate supervision and assistive devices to prevent accidents are at risk to be affected by the same noted alleged deficient practice. The Administrator and PES conducted environmental rounds to identify same alleged deficient practice. No similar findings were observed. • The facility reviewed the existing Accident Prevention Program. The accident prevention program now provides specific and clear guidelines in reducing risks and preventing accidents. Training on	

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F 323	Continued From page 22 secured. In Rooms 9, 10, 12, 14, 15, 16, 18, and 65, televisions were observed placed on top of table/carts that either wobbled when touched and/or had wheels and rolled during contact. Televisions were not secured on top of the tables/carts. On April 20, 2012, at 5:15 p.m., during an interview, LVN 3 stated she would notify the responsible department. c. On April 20, 21, and 22, 2012, Resident 4 was observed in his room during breakfast, lunch and dinner. He was observed not leaving his room. On April 21, 2012, at 7:15 a.m. and 12:35 p.m., Resident 4 was observed sitting in his bed being fed by a certified nursing assistant (CNA). On April 21, 2012, at 12:45 p.m., during an interview, Registered Nurse (RN) Supervisor 1 stated Resident 4's white blood count was low and as a precaution, staff entering his room were directed to wear mask, gown, and gloves for his protection against infection and that was the reason why he had not left his room. On April 22, 2012, at 2:26 p.m., during an interview, the director of nursing (DON) stated she was not aware of any reason why the resident was not being taken to the dining room to eat meals but stated it was possibly due to his risk for infection. A review of Resident 4's Admission Records indicated he was admitted to the facility on April	F 323	the newly revised Accident Prevention will be provided to facility staff by the DSD and PES monthly for the first 3 months then quarterly thereafter. The IDT will continue to review all incident reports during their stand up meeting to address all residents with incidents. • The implementation of the plan of correction will be monitored by the Department Supervisors through direct observation or inspection of the resident's environment during their daily Quality Circle Rounds to ensure immediate corrective actions. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random environmental tour during her scheduled facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	

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F 323	Continued From page 23 10, 2012, with diagnoses including myeloproliferative syndrome (a group of diseases of the bone marrow), late effect of stroke with right sided hemiplegia (paralysis on one side of the body) and dysphagia (difficulty swallowing). Physician's orders for Resident 4, dated April 11, 2012, indicated the following: Feed all meals in the main dining room. No eating in bed for safety. d. On 4/21/12 at 9 a.m., Resident 11 was observed sitting on his wheelchair in his room watching television (TV). The TV set was placed on top of the TV cart that had rolling wheels. The TV cart was unlocked and was moving when pushed. Resident 11 was observed to have a dressing on the right forearm. A review of the admission record indicated Resident 11 was admitted to the facility on 2/6/12 with diagnoses that included general muscle weakness. The Admission Minimum Data Set (MDS), an assessment and care screening tool, dated 2/6/12, indicated Resident 11 was assessed with moderately impaired cognitive skills (mental ability) for daily decision making, had short and long term memory problems, and required limited assistance with one person physical assistance with bed mobility, transferring, toilet use, personal hygiene, and bathing. Review of the investigative report on the incident revealed that on 4/15/12 at 4:30 a.m., Resident 11 was trying to get up from bed and wanting to go to the bathroom without assistance. The	F 323		

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F 323	Continued From page 24 resident took off his tab alarm in bed, got out of bed, held on the TV cart with rollers and caused to move him against the side rails where he sustained a skin laceration on his right forearm. Further review of Resident 11's clinical chart revealed the facility failed to develop a care plan after the incident addressing the cause of the injury, monitoring of the resident, keeping the TV set secured and TV cart stable for resident's usage. During an interview with the director of nursing on 4/21/12 at 2 p.m., she stated she will make the TV cart safe and stable for use by the resident without causing an injury.	F 323		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the dietary staff failed to follow the designed dietary spread sheet menu while preparing the residents' food from the kitchen steam table. The non-compliance has the potential for residents not to receive food in the correct amount or portion sizes to maintain their normal body weight.	F363	• Upon verbal notification of the alleged deficient practice, the Food Service Supervisor and the involved cook was apprised of the alleged deficient practice. The Food Service Supervisor provided training to all dietary cooks on 4/24/12 on Food Preparation with strong emphasis on strictly following the dietary spread sheet menu and on the corrections of the deficiency noted here. • All other residents who are not provided with the right amount or right portion sizes of food are at risk to be affected by the same noted alleged deficient practice. The FSS conducted a tray line observation on 5/1/12 to identify same alleged deficient practice. No similar findings were observed.	6/1/12

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F 363	Continued From page 25 Findings: On 4/22/12 at 12: p.m., during the tray line observation, Cook 1 was asked how she prepares the regular serving and large servings of the pot roast beef. Cook 1 stated for the noon meal, she serves 2 slices for a regular serving and 3 slices for a large serving. When asked to weigh regular slices and large slices of the pot roast beef, the following weight results were obtained: Regular cut sliced of pot roast beef: 1. 4.1 ounces (oz) 2. 3.7 oz 3. 4.3 oz Large cut sliced of pot roast beef: 1. 6.2 oz 2. 5.4 oz 3. 7.2 oz According to the facility's weekly lunch meal spread sheet, dated 4/22/12, indicated the dietary staff should be serving 3 oz for a regular portion and 4 ½ oz for a large portion. During an interview with a dietary supervisor on 4/22/12 at 12:40 p.m., she agreed the dietary staff should follow the correct weight per serving based on the dietary spread sheets.	F 363	• The Dietary Consultant will provide training to all Dietary Cooks on Food Preparation with strong emphasis on following strictly the assigned dietary spread sheet menu when preparing the residents" foods and on the correction of the deficiency noted here. The training will be done monthly for the next 3 months then quarterly thereafter. The Food Service Supervisor will conduct tray line observations daily to ensure immediate corrective actions for any identified deficient practice with regard to food preparation. • The implementation of the plan of correction is monitored by the FSS through tray line observations weekly. The effectiveness of the plan of correction will be evaluated by the Registered Dietitian during her scheduled weekly visits to the facility through direct tray line observation and interview with the dietary cooks. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	
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			

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F 425	Continued From page 26 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's nursing staff failed to administer medication as prescribed by the physician and according to the facility's policy and procedure for two of 24 sampled residents (5, 16). Resident 5 received plain multiple vitamins when multiple vitamins with minerals should have been administered. Resident 16 was administered eye drops that were not in accordance with the facility's policy and procedure. This deficient practice placed residents at risk for decrease in the effect of the medication administered and poor management of health conditions. Findings:	F 425	• a) Upon verbal notification of the alleged deficient practice, resident 16 was immediately assessed by the RN Supervisor for any possible adverse effects such as risk for decreased effect of the medication administered. The involved LVN was apprised by the DON of the alleged deficient practice. The DON provided one-on-one training to the involved LVN on proper administration of eye drops on 4/22/12. The resident is now closely monitored. b) Upon verbal notification of the alleged deficient practice, resident 5 was immediately assessed by the DON. The involved LVN was apprised of the alleged deficient practice and was provided one-on-one training by the DON on the proper and accurate administration of medication. The resident is now closely monitored. • All other residents whose mediations are not administered correctly and accurately are at risk to be affected by the same noted alleged deficient practice. The DON, DSD and Pharmacy Cons conducted random medication pass observations on 4/27/12 to identify same alleged deficient practice. No similar findings were observed. • The DON, DSD, RN Supervisors will conduct unannounced medication	6/1/12

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F 425	Continued From page 27 a. During the 9 a.m. medication pass on April 22, 2012, Licensed Vocational Nurse (LVN) 2 instilled two drops (one after another) of artificial tears into Resident 16's right eye then proceeded to instill two drops into the resident's left eye. During an interview with LVN 2, on April 22, 2012 at 10:30 a.m., he said he was nervous during the medication pass. The clinical record for Resident 16 revealed a physician's order, dated April 1, 2012, for artificial tears two drops each eye four times daily. The facility policy and procedure titled "Administration of eye drops" without a date, indicated to wait three to five minutes between each drop and each drug, which was not followed during the instillation of the eye drops. This was not followed. b. On April 22, 2012, at 6:45 a.m., LVN 7 was observed administering medication to Resident 5. LVN 7 administered all prescribed medications, including a multiple vitamin. Following the observation, all medications administered to Resident 5 were reconciled against the physician's orders. Physician's Orders, dated November 1, 2010, indicated to give Resident 5 a multiple vitamin with minerals. The resident was given a multiple vitamin without minerals.	F 425	pass observation across all shifts to evaluate staff's performance in medication administration. An in-service was provided by the Pharmacy Consultant on 4/25/12 to all licensed staff on the Proper Administration of Eye Drops and Prescribed Medications including multi-vitamins. In addition, the Pharmacy Nurse Consultant will provide training to licensed nurses on Medication Administration Policy and Procedure with strong emphasis on the correction of the deficiencies noted here. The training will be done monthly for the first 3 months then quarterly thereafter. • The implementation of the plan of correction will be monitored by the DON and DSD through random direct observation, staff interviews and record review during medication passes on a monthly basis. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random mediation pass observation during scheduled monthly facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an			

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F 441	Continued From page 28 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	• a) Upon verbal notification of the alleged deficient practice, the involved CNA who provided the care to resident 8 was apprised by the DSD of the alleged noted deficient practice. The involved CNA was provided 1-on-1 training by the DSD on 4/23/12 on Infection Control Procedures with strong emphasis on the alleged deficient practice and on the correction of the deficiency noted here. b) Upon verbal notification of the alleged deficient practice, the noted unlabeled urinal in bathroom 38 was immediately disposed of. c) Upon verbal notification of the alleged deficient practice, the involved CNA was apprised by the DSD of the alleged deficient practice. The involved CNA was provided 1-on-1 training by the DSD on 4/23/12 on Infection Control Procedures with strong emphasis on hand washing and on the correction of the deficiency noted here. d) Upon verbal notification of the alleged deficient practice, the involved CNA was apprised by the DSD of the alleged deficient practice. The involved CNA was provided 1-on-1 training by the DSD on 4/23/12 on Infection Control Procedures with strong emphasis on	6/1/12

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F 441	Continued From page 29 Based on observation, interview, and record review, the facility's nursing staff failed to wear personal protective equipment (PPE) while giving direct care to one of 24 sampled residents (Resident 8), who was on isolation precautions, and washed hands; they failed to ensure resident's urinals was labeled; they failed to wash their hands after handling soiled linen with bare hands and before picking up clean linen from the clean linen cart. These deficient practices had the potential to spread infection to other residents in the facility. Findings: a. On April 21, 2012 at 10:25 a.m., Certified Nursing Assistant (CNA) 7 was observed inside the room of Resident 8, who was on isolation, and was moving objects on the overbed table without wearing PPE, such as a gown and gloves. CNA 7 then exited the room to retrieve a straw from the hydration cart then went to the resident's bedside and assisted the resident to drink from a cup. During an interview on April 21, 2012 at 10:30 a.m., CNA 7 stated she forgot to wear PPE when she went inside Resident 8's room. She also stated she did not see the isolation cart outside the room because the hydration cart was obstructing her view. The clinical record for Resident 8 was reviewed on April 21, 2012. The Admission Face Sheet indicated the resident was admitted to the facility on April 1, 2012. A review of the physician's order, dated April 10,	F 441	hand washing and on the correction of the deficiency noted here. e) Upon verbal notification of the alleged deficient practice, the involved CNA was apprised by the DSD of the alleged deficient practice. The involved CNA was provided 1-on-1 training by the DSD on 4/23/12 on Infection Control Procedures with strong emphasis on hand washing and on the correction of the deficiency noted here. • All residents are at risk to be affected by the same noted alleged deficient practice. The Department Supervisors will observe the direct caregivers performance during ADL cares to identify same alleged deficient practice during their Quality Circle Rounds to ensure that the alleged deficient practice does not recur. • The Department Supervisors including licensed nurses will constantly remind all direct care givers to observe good Infection Control Practices by following the established policies and procedures when caring for residents on Isolation which include but not limited to wearing PPE and to prevent spread of infection by handwashing in between residents' care and labeling of bedpans and	

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F 441	Continued From page 30 2012, indicated Resident 8 was placed on strict isolation for Clostridium difficile ([C-diff] bacteria causing symptoms that range from watery diarrhea to life-threatening colitis [swelling of the large intestines]). A review of Resident 8's care plan addressing C-diff, dated April 10, 2012, indicated the facility's staff would implement isolation precautions while caring for the resident. On April 22, 2012 at 1:20 p.m., during an interview, the director of nursing (DON) stated PPE ought to be worn by staff giving direct care as long as the resident is symptomatic, that is having diarrhea and was receiving antibiotics. On April 22, 2012 at 1:30 p.m., during an interview, CNA 8, who was assigned to the resident, stated the resident has diarrhea episode daily. A review of the physician's order, dated April 10, 2012, indicated the resident was to receive antibiotics vancomycin and Flagyl for the C-diff for a total of 14 days. The undated facility policy and procedure titled "Infection Control," gloves and a gown should be worn when giving direct care or having contact with the resident's environment. b. On April 20, 2012 at 4:30 p.m., during the facility's room-to-room initial tour, an unlabeled urinal was observed in the bathroom of Room 38. There were two male residents living in the room. On April 20 2012, at 5:15 p.m., during an	F 441	urinals. The Infection Control Nurse Consultant with DSD held a training to facility staff on 5/1/12 on the Infection Control Program with strong emphasis on Prevention, Control and Spread of Infections and on the correction of the deficiencies noted here to prevent recurrence. The training will be done monthly for the first 3 months then quarterly thereafter. • The implementation of the plan of correction will be monitored by the DON and RN Supervisors through direct observation of staff's performance during their Quality Circle Rounds. The effectiveness of the plan of correction will be evaluated by the QA Nurse Consultant through random direct observation of staff's performance and random inspection of resident's personal items during scheduled facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	

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F 441	Continued From page 31 interview, Registered Nurse (RN) 5 observed the urinal and stated normally urinals were labeled with the room and bed information. The undated facility policy and procedure titled "Disinfection of Bedpans and Urinals," indicated disposable urinals are for single resident use only, and to mark with the resident's name and discard upon discharge. c. On 4/20/12 at 5:45 p.m., CNA 1 was observed holding a soiled wet towel with her bare hands. CNA 1 placed the soiled wet towel inside a soiled bin container that was parked near Room 20. CNA 1 then proceeded to pick up towels and bed sheets from a clean linen cart parked next to Room 17 without washing her hands. CNA 1 placed the clean towels and bed sheet on top of Room 17 A's bed. During an interview with CNA 1 on 4/20/12 at 5:55 p.m., she stated she was busy and forgot to wash her hands after holding the soiled linen. d. On 4/21/12 at 9:50 a.m., CNA 2 was observed coming out from Room 31 holding a bag of soiled linen with his bare hands. CNA 2 placed the bag of soiled linen in the chute. CNA 2 went back to Room 31 and picked up a clean sheet on top of an overbed table and prepared Room 31 A's bed without washing his hands. During an interview with CNA 2 on 4/21/12 at 10 a.m., he stated he was busy and forgot to wash his hands after holding the soiled linen. e. On 4/22/12 at 9:30 a.m., CNA 3 was observed coming out from Room 24 B holding a bag of	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 32 soiled linen with her bare hands. CNA 2 placed the bag of soiled linen inside a soiled linen cart. CNA 3 went back to Room 24 B and touched the resident, who was seating in her wheelchair, without washing her hands. CNA 3 pushed the wheelchair and took the resident to the activity room. During an interview with CNA 3 on 4/22/12 at 10 a.m., she stated she was in a hurry and forgot to wash her hands after holding the soiled linen. According to the facility's undated policy and procedure titled "Hand Washing", the staff should wash their hands with water and soap after each direct resident contact and after handling soiled linens.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility nursing staff failed to obtain laboratory test as ordered by a physician for one of 24 sampled residents (5), placing the resident at risk for delay in diagnosis and treatment. Findings: A review of Resident 5's Admission Records indicated she was readmitted to the facility on October 29, 2010, with diagnoses including	F 502	• Upon verbal notification of the alleged deficient practice, resident 5 was assessed by the RN Supervisor. The resident's attending physician was notified accordingly. The resident is closely monitored by the RN Supervisor to ensure that all ordered laboratory tests are done as ordered. • All other residents whose laboratory tests are not done as ordered are at risk to be affected by the same noted alleged deficient practice. The MRD and her ward clerks conducted a qualitative laboratory audit to identify same alleged deficient practice. No similar findings were noted.	6/1/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056308	A. BUILDING _____ B. WING _____	04/22/2012

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F 502	Continued From page 33 pressure ulcers (areas of damaged skin caused by staying in one position for too long). Physician's Orders, dated March 13, 2012, indicated to draw lab for pre-albumin (a test to determine protein deficiency). A review of Resident 5's laboratory test results indicated no pre-albumin were completed on March 13, 2012, as ordered. On April 22, 2012, at 2:15 p.m., during an interview, Registered Nurse (RN) Supervisor 1 stated the pre-albumin for March 13, 2012, had not been drawn.	F 502	• The DON provided in-service to licensed nurses on 5/2/12 regarding the quality and timeliness of laboratory services. The Medical Records Department developed a new system on conducting qualitative laboratory test audit. This new system provides clear guidelines to the ward clerks in conducting daily laboratory test audits and prompt and timely notification of the licensed nurses of any missed or omitted laboratory test to ensure immediate corrective actions. • The implementation of the plan of correction will be monitored by the MRD and RN Supervisor by checking the laboratory test log books daily every shift. The effectiveness of the Plan of Correction will be evaluated by the QA Nurse Consultant through random review of the laboratory tests audits validated by random record reviews during monthly scheduled facility visits. Significant findings will be submitted to the Administrator and shall be forwarded to the QA Committee for trending analysis, recommendations, corrective actions and Continuous Quality Improvement. • The corrective action was completed on 6/1/12.	