STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055161	A. BUILDING _____ B. WING _____	06/11/2016

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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 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a RECERTIFICATION SURVEY: Representing the Department of Public Health: Surveyor ID # 25046, HFEN Surveyor ID # 09697, HFEN Surveyor ID # 22303, HFEN Total Census: 59 Total Sample: 15 S/S - D	F 000		
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, interview, and record review, the facility interdisciplinary team (IDT) failed to ensure that a resident would not be allowed to keep medications at the bedside without a physician's order and/or without being assessed to determine the resident is capable to self-administer medications for one of 15 sample residents (Resident 2). Findings:	F 176		

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LOS ANGELES COUNTY HEALTH FACILITIES DIVISION

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

Administrator 7-5-16

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 176	Continued From page 1 On June 11, 2016, at 8:30 a.m., during morning rounds, Resident 2's bedside table was observed with a box of Mucinex (for cough and mucus) containing 5 tablets. At 10:30 a.m., during the medication pass observation , the medication was still at the bedside table. The licensed vocational nurse (LVN 2) was interviewed with a review of the clinical record, which revealed there was no documentation to indicate the resident was assessed by the IDT that he was a candidate to self-administer medication. There was no physician's order for the Mucinex medication. LVN 2 was unable to explain why the medication was at Resident 2's bedside. Review of Resident 2's clinical record indicated he was readmitted to the facility on June 9, 2016, with diagnoses that included sepsis (infection) with acute organ dysfunction. Resident 2 was alert and verbally responsive and required assistance with care needs. According to the facility's policy on Self-Administration of drugs, the interdisciplinary team, including the attending physician, determines that it is safe for the resident to self-administer medications.	F 176	F – 176: Immediate Action: Removed Resident 2's medications from bedside and explained risks/benefits of keeping medications with resident. Assessment for self-administration medication was completed. Identification Of Other Affected residents: All Residents could be potentially affected if medications are left at bedside without proper assessment. All Licensed Nurses were re in-serviced on policies and procedures regarding resident self-medication. Systematic Changes: The Supervisor will include follow-up/review on self-administration of medications for new residents during first 24 hours. Violation of the policy will be brought to the attention of the DON for corrective action. Quality Assurance:. Any non-compliance will be corrected as it is noted. A report shall be made to the Quality Assurance and Assessment Committee for further review and recommendation.	7/5/16
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	F 281		

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F 281	Continued From page 2 by: Based on observation, interview and record review, the facility failed to ensure oxygen was administered as ordered by the physician for one out of 15 sample residents (Resident 14). This deficient practice can place the resident at risk to have carbon dioxide retention (abnormally elevated carbon dioxide levels in the blood). Findings: According to the admission record, Resident 14 was admitted to the facility on June 3, 2016, with diagnoses that included congestive heart failure, atrial fibrillation (irregular heart beat) and interstitial pulmonary disease (a group of diseases affecting the tissue and space around the air sacs of the lungs). The resident had a physician's order dated June 5, 2016, to administer oxygen down to two liters per minute. A review of Resident 14's plan of care dated June 6, 2016, indicated the potential for ineffective breathing pattern and altered respiratory status related to atrial fibrillation, congestive heart failure, and interstitial pulmonary disease. One of the approaches was to administer oxygen as ordered. On June 10, 2016, at 5:25 p.m. and at 8:40 p.m., Resident 14 was observed receiving five liters of oxygen per minute via nasal cannula. On June 10, 2016, at 9 p.m. during an interview with Registered Nurse 1 (RN 1), he stated the oxygen should have been administered to the resident 2 liters per minute as the physician ordered.	F 281	F – 281: Immediate Action: Assessed Resident 14's oxygen saturation immediately following question from Surveyor. Physician's order for oxygen was clarified to include oxygen amount. Identification Of Other Affected Residents: All Residents on oxygen were reviewed to ensure correct oxygen amount was followed as per orders. Systematic Changes: Licensed nurses will review residents for appropriate oxygen administration during daily rounds. Quality Assurance: The Supervisor will monitor that licensed nurses adhere to physicians' orders. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment Committee for further review and recommendation.	7/5/16

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F 281	Continued From page 3 A review of the reference indicated in a patient (resident) with chronic lung disease, it is important to consider the possibility of carbon dioxide retention when breathing an increased fraction of oxygen [British Medical journal 1998 September 26:317 (7162) 871-874].	F 281		
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 failed to ensure residents who required extensive assistance from the staff with personal hygiene and grooming had their fingernails trimmed for one of 15 residents (Resident 1). Findings: A review of Resident 1's admission records indicated the resident was readmitted to the facility on May 2, 2016, with a past stroke with right-sided weakness and generalized weakness. A review of the Minimum Data Set (MDS) a standardized assessment and care screening tool dated May 15, 2016, indicated Resident 1 had short and long term memory problems with severely impaired decision-making. Resident 1 required extensive assistance from staff to	F 312	F – 312: Immediate Action: Following observation by the Surveyor on June 11, Resident 1's nails were clipped. Identification Of Other Affected Residents: DSD assistant conducted rounds to ensure that all residents have appropriate nail length. No other residents required fingernails clipped. Systematic Changes: In-service was provided to the CNAs regarding proper grooming – i.e. nail care. Daily rounds will be conducted by the Supervisor and DSD observing resident ADL care. Failure to provide appropriate care will be brought to the DON for corrective action. Quality Assurance: Any non-compliance will be corrected immediately. A report, if required, shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/15/16

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F 312	Continued From page 4 complete personal hygiene and grooming. On June 10, 2016, at 5 p.m., Resident 1 was observed in her bed. Her fingernails were long. Her right hand was under the blanket and the fingernails were long. Resident 1's family member was at the bedside, and was interviewed, along with Resident 1. They were asked if the resident wanted her fingernails to be trimmed. Resident 1 responded by nodding her head "yes"; the family member was not aware the fingernails were long.	F 312		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a resident was provided bowel and bladder retraining as ordered by the physician for one of 15 sample residents (Resident 14). This deficient practice had potential for preventing the resident from being able to restore their normal bowel and bladder capabilities.	F 315		

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F 315	Continued From page 5 Findings: On June 9, 2016, at 5:25 p.m., Resident 14 was observed lying in his bed, and was able to communicate. There was a urinal (device for males to urinate in) hooked on the bedside rail. According to the admission record, Resident 14 was admitted to the facility on June 3, 2016, with diagnoses that included congestive heart failure. The resident had a physician's order dated June 6, 2016, for bowel and bladder retraining. There was a plan of care developed for frequent bowel and urinary incontinence. One of the approaches was to provide bladder-retraining program per policy, and to monitor and document the result. A review of Resident 14's clinical record indicated there was no documented evidence the resident was retrained for bowel and bladder control (such as offering to use the bathroom, a urinal or bed pan). A review of the facility's policy of the "Toileting Program", established in the year of 2008, indicated toileting can be done by taking the resident to the bathroom, using a commode, or a bedpan depending on the resident's request and individual needs or physical/cognitive condition. A review of the facility's policy of the "Bowel Management (Retraining) Program", established in the year of 2008, indicated to document the retraining schedule on the plan of care, and to place the resident on the bedpan or take to the bathroom at approximately 30 to 45 minutes before the time that has been established as the	F 315	F-315: Immediate Action: Confirmed with Resident 14 and resident's CNA that a bowel & bladder retraining program was in place. Supervisor reviewed facility's current log to monitor progress. Identification Of Other Affected Residents: All Residents currently on a bowel & bladder program were re-assessed to ensure that bowel & bladder plan of care is being followed. Systematic Changes: Facility has reviewed the current bowel & bladder program log. Changes have been made to reflect additional monitoring and documentation of bowel & bladder retraining. CNAs were in-serviced on changes to documentation. Medical records will audit documentation compliance. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/5/16

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F 315	Continued From page 6 regular time for the resident to have a bowel movement (see care plan).	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the residents received the correct amount of the gastrostomy tube (GT) feeding formula for one of 15 sampled residents (Resident 5). This deficient practice placed the residents at risk for weight loss and dehydration. Findings:	F 322	F-322: Immediate Action: Licensed staff were immediately given a 1-on-1 in-service regarding proper GTF administration for Resident 5. Identification Of Other Affected Residents: All residents with enteral feeding were reviewed for proper administration times and no discrepancy was noted. Systematic Changes: All residents currently receiving enteral feeding were observed for proper amount of feeding. Supervisor will monitor proper administration during daily rounds. Failure to follow facility protocol will result in disciplinary action. DON will monitor. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/15/16

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F 322	Continued From page 7 A review of the admission record indicated Resident 5 was admitted to the facility on September 14, 2015, with diagnoses that included difficulty in walking, hypertension (high blood pressure) and Gout (pain and tenderness in joints). The resident had a gastrostomy tube [(GT) - tube inserted through the skin into the stomach for feeding and medication administration]. The Minimum Data Set (MDS) a standardized assessment and care screening tool, dated April 8, 2016, indicated the resident was unable to make his needs known. The resident was totally dependent on staff for transfers, eating, toileting, and personal hygiene. There was a physician's order dated September 14, 2015, to provide Fibersource HN 1.2 (GT feeding) via enteral pump to run at 75 cubic centimeters (cc) per hour for 20 hours; to provide 1500 cc in 24 hours. Start infusion at 1 p.m. and to stop at 9 a.m., or until total volume is given. During a tour of the facility on June 10, 2016, at 5:30 p.m., Resident 5 was observed lying in bed with Fibersource HN 1.2 formula bottle (1500 cc) infusing at 75 cc per hour. The formula bottle was labeled with a start date and time of June 10, 2016, at 6 a.m., at 75 cc per hour, and there was 1400 cc formula left in the bottle. According to the label on the formula bottle indicating that the Fibersource HN was started at 6 a.m., Resident 5 should have received feeding for a total of 7 hours and 30 minutes, equal to an infused total volume of of 562 cc. However, during the observation, the formula bottle	F 322		

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F 322	Continued From page 8 contained 1400 cc, or 462 cc more formula than was expected, if the volume of feeding was provided as the physician ordered. A care plan dated April 21, 2016, for potential for increase risk of aspiration from gastrostomy tube had an intervention to administer tube feeding rate and formula as ordered. During an interview with the director of nurses (DON) on June 11, 2016, at 4 p.m., the DON stated the total volume of infusion that was ordered was not met.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident who was assessed as a high risk for falls, and had a recent fall, had an updated plan of care with appropriate interventions for one of 15 sampled residents (Resident 6); and the housekeeping staff failed to lock the housekeeping cart when unattended. This deficient practice placed Resident 6 at risk for further falls and/ injury; and had a potential for residents who may have access to the cart, to be injured due to chemicals	F 323		

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F 323	Continued From page 9 left unsecured. Findings: a. On June 9, 2016, at 6 p.m., during an initial tour of the facility, Resident 6 was observed sitting in her wheelchair at the activity room. The resident had no tab alarm applied to her wheelchair. A review of the admission record indicated Resident 6 was re-admitted to the facility on September 28, 2015, with diagnoses including osteoporosis (brittle bones). The Minimum Data Set (MDS, standardized assessment and care screening tool), dated March 28, 2016, indicated Resident 6 was moderately impaired with her cognitive skills for daily decision-making and required extensive assistance from staff with care needs. A Fall Risk Assessment dated March 29, 2016, indicated Resident 6 was assessed for fall and had a score of 21 indicating a high risk for fall. A review of Resident 6's Nursing Notes dated April 18, 2016, at 1 p.m., indicated the resident was found lying on the floor next to her wheelchair at her bathroom with no injury sustained. The care plan for falls was not updated to reflect new interventions to prevent falls after the actual fall on April 18, 2016. On June 11, 2016, at 4 p.m., during an interview, the director of nurses (DON) stated the care plan was not updated after the April 2016 fall. The	F 323	F –323: Immediate Action: A) Care plan was updated on Resident 6. B) Housekeeping cart immediately locked upon observation by Surveyor. Identification Of Other Affected Residents: A) Reviewed other high fall-risk residents for updated care plans based on current Incident Reports. B) Reviewed other housekeeping carts, to ensure they were locked. In-service was conducted to housekeeping on importance of keeping cart locked at all times. Systematic Changes: A) In-serviced all licensed staff on the facility policy for updating care plans after any incident. Medical records will conduct periodic audits. B) Environmental Service Director and Administrator conducted in-service to housekeeping staff regarding locking carts. Environmental Supervisor will conduct random observation of staff techniques. Action Plans will be developed for non-compliant trends. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/5/16

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F 323	Continued From page 10 DON stated the care plan was to be updated and revised after any fall. According to the facility's undated policy and procedure titled "Fall Management Process", a fall risk score of 10 or above represents high risk for fall and will require the development of a nursing care plan with appropriate interventions initiated and implemented designed to prevent falls. b. On June 11, 2016, at 10:30 a.m., during an observation. the housekeeping cart was observed at the doorway between Room 34 and 35. The housekeeping cart top drawer was not locked and when opened by the evaluator, there were five spray bottles and chemical liquid bottles. There was a warning sign "Keep out reach of children". The housekeeper staff provided the cart key and stated he forgot to lock the cart. When interviewed at the time of the observation, he stated that the cart should be locked at all times.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL 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.	F 328		

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F 328	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's peripherally inserted central catheter (PICC) dressing was changed every seven days as indicated in the facility's policy for one of 15 sample residents (Resident 14). This deficient practice had the potential to cause infection of the resident's PICC site. Findings: According to the admission record, Resident 14 was admitted to the facility on June 3, 2016, with diagnoses that included bacteremia (bacteria in the blood). Resident 14 had a physician's order dated June 4, 2016, for Ampicillin Sodium 2 gram solution reconstituted via intravenous route (IV) every eight hours for infection, and to change dressing as necessary. On June 10, 2016, at 5:25 p.m., Resident 14 was observed with a PICC line to his left upper arm. There was a transparent dressing on the PICC site, which was dated June 2, 2016 (eight days ago). The edge of the transparent dressing was loose and peeling off. On June 10, 2016, at 8:40 p.m., during an interview with Registered Nurse 1 (RN 1), he stated the dressing over the PICC should have been changed every seven days. A review of the facility's policy of the "PICC	F 328	F-328: Immediate Action: Resident 14's PICC line dressing was changed immediately. Identification Of Other Affected Residents: All residents with PICC lines were assessed for timely and appropriate dressing changes. No other residents found with outdated dressing change. Systematic Changes: All RNs were in-serviced regarding the facility policy of changing PICC line dressings every 7 days. Medical Records will audit all IV MARs for compliance. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/5/16

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F 328	Continued From page 12 Dressing Change" dated March 2014, indicated the PICC dressing should be changed at least weekly.	F 328		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

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F 441	Continued From page 13 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent the spread of infection by not providing the resident with a storage receptacle or cover for the incentive spirometer (a device blown into, used to help residents improve the functioning of their lungs) for random sample resident (RSR) 16. This had the potential for contamination and to cause respiratory infections. Findings: On June 9, 2016, at 5:30 p.m., during the tour of the facility, RSR 16 was observed in his room on bed. He was alert and verbally responsive and required assistance with his care needs. There was an uncovered incentive spirometer at the resident's bedside table. When inquired if he used the device, he stated he used it at times to exercise his lungs. He stated his physician instructed him to use the device also after he was discharged. On June 10, 2016, at 6 p.m., the incentive spirometer was still uncovered, and at the resident's bedside table. The registered nurse (RN2) stated the device should be placed in a plastic receptacle to maintain cleanliness and to prevent infection.	F 441	F-441: Immediate Action: Resident 16's incentive spirometer was immediately wiped down and placed in a labeled bag per facility policy regarding equipment. Identification Of Other Affected Residents: There were no other residents with incentive spirometers. Other respiratory equipment in resident rooms was appropriately labeled and bagged. Systematic Changes: All nursing staff was in-serviced regarding revised policy (which includes incentive spirometers). All patient belongings relating to respiratory are to be wiped down and stored in a labeled bag. Supervisor will monitor for compliance during daily rounds. Quality Assurance Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/5/16

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F 458 SS=B	Continued From page 14 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet the requirement of 80 square feet per resident in multiple resident bedrooms. This failure had the potential for inadequate space for the health care staff to perform their duties safely, and to impact on the residents' quality of life. Findings: On June 11, 2016, at 10 a.m., the administrator provided information regarding a request for a continuing waiver for Rooms of 21, 22, 23, 24, 25, 26, 27, 28, 33, 34, 35, 36, 37, and 38. According to the Client Accommodation Record submitted by the administrator, the rooms and the space measurement were as follows: Room No. Room size Beds Square footage Room 21 151.69 2 75.8 Room 22 289.53 4 72.4 Room 23 150.50 2 75.3 Room 24 151.69 2 75.8 Room 25 150.50 2 75.3 Room 26 150.50 2 75.3 Room 27 150.50 2 75.3 Room 28 151.38 2 75.7	F 458 F 458	F-458: Immediate Action: The facility has a waiver for Rooms 21, 22, 23, 24, 25, 26, 27, 28, 33, 34, 35, 36, 37 and 38 Identification Of Other Affected Residents: The Administrator has requested a continuation of the WAIVER REQUEST. The Surveyors noted that there no problems related to space in the rooms under waiver. Systematic Changes: The facility will continue to make sure that the rooms under waiver approval have adequate/appropriate space for the residents. Quality Assurance: Any concerns with the rooms under waiver will be brought to the QA&A by the Administrator for review/recommendations.	7/5/16

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F 458	Continued From page 15 Room 33 149.63 2 74.8 Room 34 148.44 2 74.2 Room 35 146.06 2 73 Room 36 147.25 2 73.6 Room 37 146.06 2 73 Room 38 148.44 2 74.2 At the time of the observation, there were no concerns observed or related to space or to the safe provision of care to the residents residing in the involved rooms.	F 458		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the laboratory tests were provided as ordered by the attending physician for one of 15 sample residents (Resident 10). Resident 10 had an order for Vancomycin (antibiotic) trough level (levels to test effectiveness of the antibiotic) that was not done. This deficient practice had the potential to place the antibiotic dosing level ineffective to resolve infection. Findings: According to the Record of Admission, Resident 10 was admitted to the facility on April 26, 2016, with diagnoses which included bacterial arthritis of the left knee and difficulty of walking.	F 504		

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F 504	Continued From page 16 The Minimum Data Set (MDS, standardized assessment and care screening tool), dated June 1, 2016, indicated Resident 10 was severely impaired with her cognitive skills for daily decision-making and required limited assistance from staff with care needs. There was a physician's orders dated June 8, 2016, to administer Vancomycin 750 milligrams (mg) via intravenously (IV) every 18 hours for six weeks; to draw Vancomycin trough level on June 11, 2016 at 1:30 a.m. for infection. On June 10, 2016, at 7 p.m., Resident 10 was observed lying in bed with a IV to her right arm. A review of Resident 10's Diagnostic Laboratory results dated June 11, 2016, indicated no Vancomycin trough level results. On June 11, 2016, at 10 a.m., during an interview with the registered nurse (RN 2), she stated there was no laboratory personnel to come to the facility to draw Resident 10's blood for Vancomycin trough level on June 11, 2016, at 1:30 a.m.	F 504	F-504: Immediate Action: Resident assessed for signs/symptoms of medication toxicity, with none observed. Kaiser IPPG phlebotomy notified, with blood draw scheduled for 8pm same day. MD made aware. Identification Of Other Affected Residents: There were no other residents requiring antibiotic trough draws at this time. Systematic Changes: Supervisors in-serviced on follow-up with Kaiser IPPG labs service hours, to call and verify phlebotomist to draw antibiotic trough levels at expected hours. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/5/16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 17 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's clinical record was maintained in accordance with accepted professional standards and practice that are accurate, by not documenting the intravenous fluid (IV) medication sheet correctly for one of 15 sample residents (Resident 14) who had a peripherally inserted central catheter (PICC) . This deficient practice had the potential to prevent appropriate provision of care/intervention to the resident. Findings: According to the admission record, Resident 14 was admitted to the facility on June 3, 2016, with diagnoses that included bacteremia (blood infection). The resident had a physician's order dated June 4, 2016, for Ampicillin Sodium 2 gram solution via intravenous (IV) every eight hours for infection, and to change dressing as necessary. On June 10, 2016, at 5:25 p.m., Resident 14 was observed with a peripherally inserted central catheter (PICC) to his left upper arm. There was a transparent dressing on the PICC site dated June 2, 2016 (eight days). A review of the intravenous fluid (IVF) medication	F 514	F-514: Immediate Action: In-service was given to RNs regarding proper documentation for Resident 14 of peripheral IV site and PICC line. Identification Of Other Affected Residents: Reviewed residents with IV orders and confirmed correct documentation of peripheral IV sites and PICC lines. Systematic Changes: Supervisors to monitor correct documentation of peripheral IV sites and PICC lines. Pharmacy and Medical Records to conduct periodic audits on IV MAR. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendation.	7/5/16

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F 514	Continued From page 18 sheet indicated the resident's subcutaneous IV site had been restarted on June 4, 2016, at 1 p.m., June 7, 2016, at 1 p.m., and on June 10, 2016, at 12 p.m. On June 10, 2016, at 8:40 p.m. during an interview with Registered Nurse 1 (RN 1), he stated the IVF medication was documented incorrectly. RN 1 stated the resident had a PICC line, not an IV, and the PICC site was not changed on June 4, 2016, at 1 p.m., June 7, 2016, at 1 p.m., and on June 10, 2016, at 12 p.m., as evidenced by the date on the PICC site transparent dressing. A review of the facility's policy of the General Documentation indicated the resident's clinical record should accurately reflect current condition.	F 514		