STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING _____ B. WING _____	05/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	4635 COLLEGE OAK DRIVE SACRAMENTO, CA 95841

POC accepted 7/17/15 LSPinkham HFES

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: HFEN, 28392/2377 HFEN, 29721/2516 HFEN, 29583/2493 HFEN, 32525/2670 The facility census was 100 and the sample size was 20.	F 000	Preparation and/ or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/ or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 CFR 405.1907.	
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 failed to ensure physician orders were followed for 1 of 20 sampled residents (Resident 8), when oxygen was not administered as prescribed. This failure increased the potential risk that Resident 8's oxygen saturation levels (level of oxygen in the blood) could decline. Findings: Resident 8 was admitted to the facility in early 2015 with diagnoses of pulmonary (lung) disease and oxygen dependence. A review of Resident 8's quarterly Minimum Data	F 281	**F281** **Immediate Correction:** The Charge Nurse contacted the Physician and obtained a Telephone Order to decrease the O2 from 4L/ min to 2L per minute, per the Resident's request. Resident 8's Care Plan was updated to include that the patient sometimes changes the O2 setting on his own concentrator as he deems necessary. Resident 8 was provided information on O2 use and requested to communicate his varying O2 needs to his Charge Nurse.	5/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rina Kaplow — TITLE: Administrator — (X6) DATE: 7/14/15

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 281	Continued From page 1 Set (an assessment tool), dated 4/15/15, indicated Resident 8 was usually able to understand others and was usually understood by others. Resident 8's Brief Interview for Mental Status score was a 10/15, which indicated Resident 8 was moderately cognitively impaired. A review of Resident 8's physician's orders, dated 5/1/15 through 5/31/15, stipulated, "O 2 (oxygen) @ (at) 4 L/MIN (liters per minute) VIA NC (nasal cannula) CONTINUOUSLY FOR COPD (chronic obstructive pulmonary disease). During the Entrance Tour on 5/19/15 at approximately 9:30 a.m., and again on 5/20/15 at 9:10 a.m., Resident 8 was observed in his room with oxygen on via nasal cannula. The oxygen concentrator tank indicated the oxygen was given at 2 and 1/2 L/MIN. During an interview with Resident 8 on 5/19/15 at 3:30 p.m., Resident 8 stated, "When I was at the hospital (in January 2015), they told me it would be good idea to get it (oxygen) down below 4, at 2-3 L/MIN. That's what I've had it at." The undated facility policy and procedure titled "Oxygen Storage and Use," was reviewed. The policy stipulated, "The nurse shall monitor oxygen administration and record the resident's use of oxygen therapy in the medical record." A review of the Medication Administration Record, dated 5/1/15 through 5/31/15, indicated, "1/10/15 O 2 @ 4 L/MIN VIA NC CONTINUOUSLY FOR COPD." The licensed nurses had initialed on every shift that Resident 8 received oxygen at 4 L/MIN as prescribed.	F 281	**Identification of Other Residents Having the Potential to be Affected:** All residents having oxygen orders were observed and compared against their oxygen orders. There were no other residents that had their oxygen set at a level different from their physician's order. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** All Nursing Staff were inserviced regarding following Physician's Orders, especially with regards to oxygen orders. Nurses were inserviced that charting with regards to Oxygen use means verifying that the Resident's Oxygen Concentrator is set at the level that matches the Medication Administration Record and Physician's Order. **Monitoring Process:** QA Form developed that randomly selects residents on oxygen and observes what the residents oxygen is set at on the concentrator compared to what is ordered by the phsycian. The form will be completed monthly by the DSD to ensure compliance. QA results to be monitored by QA Committee.	6/9/15 6/9/15 6/12/15 and ongoing

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F 281	Continued From page 2 During a concurrent interview with Resident 8 and Licensed Nurse 3 on 5/19/15 at 3:30 p.m., Licensed Nurse 3 stated, "I wasn't aware he was only using 2 1/2 L of O 2. I'll call the doctor and get an order change."	F 281	**F332** **Immediate Correction:** The Charge Nurse was administering medications beginning at 7:00pm. During her medication pass, another resident experienced a fall. The Charge Nurse pulled open the rings of the MAR Binder and pulled the Medication Administration Record pages and moved them up by one ring in the MAR binder, to alert her to return to those pages for review. When she returned from assisting the other Resident, the Surveyor had already pulled the MARs for her own review. The Charge Nurse continued on her med pass. At 7:35pm, the Surveyor returned with the MARs belonging to the Resident who had been administered some of her medications and informed the Charge Nurse that two medications were missed. The Charge Nurse stated that she would give them "right away." The Charge Nurse administered the two remaining medications at 7:35pm. The Charge Nurse's practice is to return to the MAR to verify that all meds are given. The Resident was administered the medications within the time allotted for Medication Administration. The Charge Nurse did not state to the	5/20/15
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from a medication error rate of 5 percent or greater, for a census of 100, when 2 medications were omitted for Resident 10 during observation of 32 medication administration opportunities. The omissions resulted in an error rate of 6.25 percent. Findings: Resident 10 was admitted to the facility last year with multiple diagnoses that included hyperlipidemia (high cholesterol) and peripheral neuropathic pain (nerve pain). During a Medication Administration Observation on 5/20/15 started at 7:15 p.m., Licensed Nurse 2 (LN 2) was observed as medications for Resident 10 were prepared. Resident 10 sat up in a wheelchair in the hallway near the North nurse's station. LN 2 counted the number of tablets for a total of 5 doses and administered the medications	F 332		

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F 332	Continued From page 3 to Resident 10. LN 2 omitted 2 doses for Resident 10. LN 2 then proceeded to the next resident. During a review of the physician orders and reconciliation with the Medication Administration Record (MAR) for Resident 10, the following orders were noted: 12/05/14: Gabapentin 200 milligram (mg) to take 1 capsule by mouth 3 times a day for neuropathic pain. The administration times scheduled on page 2 of the MAR were 8 a.m., 2 p.m., and 8 p.m. Gabapentin was not given to Resident 10 during the medication administration observation on 5/20/15. 12/05/14: Simvastatin 40 mg 1 tablet to be given by mouth every night for hyperlipidemia. The administration time scheduled on page 1 of the MAR was 8 p.m. Simvastatin was not given to Resident 10 during the medication administration observation on 5/20/15. A review of the facility's undated "Medication Administration" policy indicated, "To accurately administer medication to residents. Medications shall be administered as ordered by a licensed nurse upon the order of a physician/licensed independent practitioner." During an interview and concurrent physician orders review with LN 2 on 5/20/15 at 7:35 p.m., LN 2 was asked to verify which medications Resident 10 received during the medication administration observation. LN 2 reported she did not give Resident 10 Simvastatin (the cholesterol medication) and Gabapentin (the medication for nerve pain) and stated, "I will give them right	F 332	Surveyor that she would return from another patient incident to continue passing the meds to Resident 10. **Identification of Other Residents Having the Potential to be Affected:** There were no other incidents that interrupted a nurse's med pass, therefore no other residents were affected. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The Charge Nurse identified was observed for a Med Pass Observation by the Pharmacy Consultant on 6/3/2015. All Charge Nurses will participate in at least one Med Pass Observation by the Pharmacy Consultant on an annual basis. Nurses have been inserviced to communicate to someone when their med pass is interrupted but will be completed upon their return. **Monitoring Process:** A Med Pass Observation QA will be conducted on at least two nurses per month. The QA form directs the observer to observe the MAR and note the total number of pills to be administered for a particular patient, then record the actual number of pills observed for administration. Director of Nursing	5/20/15 6/13/15 7/14/15 and ongoing

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F 332	Continued From page 4 away."	F 332	to monitor for compliance by randomly quizzing the Charge Nurses what they do when a Med Pass is interrupted. Pharmacy Consultant Med Pass Observations will be reviewed quarterly by QA Committee.	6/12/15 and ongoing
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain food at palatable temperatures when food temperatures from a test tray were below 140 degrees Fahrenheit. Findings: Thermometers were calibrated in the kitchen prior to the beginning of tray line. During Tray Line observation on 5/20/15 at approximately 12:08 p.m., a lunch cart was observed as it left the kitchen with 3 plates on top. The three plates had a cover on them, but no plate warmer underneath them. Two of the three plates belonged to Random Resident 21 and Random Resident 22. In a concurrent interview with the Food Services Supervisor (FSS) on 5/20/15 at 12:08 p.m., she stated, "The cart was full." During Tray Line on 5/20/15, a test tray was sampled for temperature control and palatability. The sampled tray included chicken, brown rice, zucchini (alternate carrots), and oriental green	F 364	**F364** **Immediate Correction:** There is no opportunity to complete immediate correction, as Facility staff were made aware of these complaints at exit conference on 5/22/15. Also, the Confidential Residents List provided to the Facility does not identify Residents 21 and 22. **Identification of Other Residents Having the Potential to be Affected:** Food Satisfaction discussed at Resident Council, and explained that Residents may request another tray or item when they are dissatisfied with item(s) served. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Nursing Staff were inserviced regarding Resident Food Satisfaction, and to offer the Resident another plate from the Kitchen if food is not satisfactory for any reason.	6/10/15 6/9/15

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F 364	Continued From page 5 salad. After the last resident was served their meal in the Main Dining Room, the temperatures were taken at 12:34 p.m. by the FSS and the Department. The temperatures were as follows: Chinese chicken- 152 degrees Fahrenheit Carrots-110 degrees Fahrenheit Brown rice- 120 degrees Fahrenheit. In an interview with Random Resident 21 on 5/20/15 at 12:50 p.m., she stated, "Food was alright. I didn't like the chicken. It was warm." In an interview with Random Resident 22 on 5/20/15 at 12:59 p.m., she stated, "It (food tray) comes a long way from the kitchen...not very warm...could have been warmer."	F 364	**Monitoring Process:** QA Form developed and implemented to interview Residents for their Food Satisfaction. Form also includes data for Food Temperatures on Test Tray. QA Form will be completed monthly by Dietary Supervisor. QA Data to be reviewed Quarterly by QA Committee.	6/12/15 and ongoing
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a sanitary environment when: 1. A kitchen floor drain backed up into the food	F 371	**F371(1)** **Immediate Correction:** Facility implemented its Internal Disaster Plan successfully. The Plumber was able to clear the drain by 6:20pm on 5/19/15. The Dietary Department was entirely sanitized prior to re-opening for food service on 5/20/15. The drains have not backed up since the incident on 5/19/15. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** A previous Maintenance Employee who was consulted during the internal disaster with regards to Dietary Department Clean-Outs stated that historically the Dietary Department was on a semi-annual schedule of hydro-cleaning the drains in the Dietary Department, and this process had been omitted for	5/19/15 5/19/15 and ongoing

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F 371	Continued From page 6 preparation area and caused the facility to implement emergency procedures for a dinner meal; and 2. Food items were found in the freezer uncovered and not labeled; and 3. A kitchen staff's thumb touched the inside of dessert and salad bowls; and two kitchen staff walked away from tray line and returned, with their ungloved hands unwashed, to the tray line. These failures increased the potential risk for the spread of food borne illness. Findings: 1. During the Initial Kitchen Tour on 5/19/15 started at 7:45 a.m., the air gap (unobstructed vertical space between the water outlet and the flood level of a fixture) under the counter, to the right of the prep sink, was noted to have pooled water in the drain. There was approximately 1 to 2 inches of water inside. In a concurrent interview with the Food Services Supervisor (FSS) on 5/19/15 at 7:45 a.m., she acknowledged the water in the drain and stated, "I'll call the plumber. It's happened before." At approximately 4:30 p.m., on 5/19/15 the Department was informed that two kitchen floor drains were backed up. A clogged drain was backed up with brownish-orange liquid. The drain, located to the right of the stove top oven, had been used to dispose of grease and fat. This caused the sloped floor drain, located approximately 3 feet diagonally across from the grease drain and approximately 2 feet across from the prep sink, to back up. The sloped floor drain had brownish	F 371	approximately 18 months. This process was reinstated effective 5/19/15, and a routine semi-annual schedule for hydro-cleaning the drains has been implemented. **Monitoring Process:** All Drain Cleaning Vendor Invoices shall be reviewed quarterly by the QA Committee to identify trends to modify cleaning schedule as indicated. Maintenance Director and Administrator shall ensure compliance. **F371(2)** **Immediate Correction:** The identified bag of burritos and the identified bag of chicken were removed from the freezer and disposed of. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Dietary Staff were inserviced regarding Procedures for Freezer Storage, which include labeling items with the date they are opened when placed back in the freezer. **Monitoring Process:** Dietary Supervisor shall QA on a weekly basis to ensure compliance with Freezer Storage and Labeling. QA Results shall be reviewed by QA Committee on a quarterly basis.	6/12/15 and ongoing 5/19/15 6/16/15 6/12/15 and ongoing

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F 371	Continued From page 7 water pooled around it, approximately 1 foot in circumference. At 4:40 p.m. on 5/19/15, the facility had already moved the steam table into the adjoining dining room. The Administrator and the Registered Dietician discussed whether or not the prepared dinner temperatures could be maintained, as the facility recognized they did not have a 240 volt electrical outlet plug for the steam table. Food temperatures were taken. The vegetables were measured at 160 degrees Fahrenheit and the pureed fish was measured at 130 degrees Fahrenheit. The facility implemented it's emergency food menu for dinner. A review of the plumbing invoices for September 2014, January 2015, and March 2015 revealed the following; 9/5/14-"Multiple floor drains backed up...cleared of grease" 1/27/15- "Dishwasher drain in kitchen backed up." 3/19/15- "Found kitchen floor drains backed up...cleared line of heavy grease from cleanout in front of rinse station...recommend general Jett line (high power flushing of line)." In an interview with the Management Supervisor on 5/19/15 at 5:18 p.m., she stated, "I've seen this happening before, but not this bad. Usually the FSS will tell me when it's (the grease drain) is backing up a little and I call the plumber...No one told me about the drain this morning." According to the US Food and Drug Administration, Food Code 2009, Chapter 5 Water, Plumbing and Waste, "Backflow Prevention...Improper plumbing installation or maintenance may result in potential health	F 371	**F371(3)** **Immediate Correction and Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Dietary Staff were inserviced with regards to handwashing procedures. Dietary Staff were trained to wash or sanitize hands prior to working trayline. **Monitoring Process:** Dietary Supervisor shall ensure compliance with handwashing prior to trayline. QA observations shall be conducted periodically by the Registered Dietitian and reviewed quarterly by the QA Committee. **F465(1)** **Immediate Correction:** The Plumber was able to clear the drain by 6:20pm on 5/19/15. The Dietary Department was entirely sanitized prior to re-opening for food service on 5/20/15. The drains have not backed up since the incident on 5/19/15. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** A previous Maintenance Employee who was consulted during the internal disaster with regards to Dietary	6/16/15 6/12/15 and ongoing 5/19/15 5/19/15 and ongoing

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F 371	Continued From page 8 hazards such as cross connections, back siphonage or backflow. These conditions may result in the contamination of food, utensils, equipment, or other food-contact surfaces. It may also adversely affect the operation of equipment such as warewashing machines. Grease Trap-Failure to locate a grease trap so that it can be properly maintained and cleaned could result in the harborage of vermin and/or the failure of the sewage system." In an interview with the Administrator on 5/19/15 at 6:20 p.m., she reported the kitchen does not have a grease trap. 2. During the Initial Kitchen Tour on 5/19/15 started at 7:45 a.m., a large plastic bag of frozen burritos was found opened in the meat freezer and a previously opened bag of chopped chicken in the second meat freezer did not have an open date on it. A review of the undated facility policy and procedure entitled, "PROCEDURE FOR FREEZER STORAGE," indicated, "Store frozen foods in an airtight moisture resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. All frozen food should be labeled and dated." In a concurrent interview with the FSS on 5/19/15 at 8:06 a.m., she confirmed the open bags of food needed to be sealed and labeled once opened. 3. During Tray Line on 5/20/15, between 11:30 a.m. and 12:10 p.m., 2 dietary aides assisted with tray line. At 11:40 a.m., Dietary Aide (DA) 2 was observed when his thumb touched the inside of	F 371	Department Clean-Outs stated that historically the Dietary Department was on a semi-annual schedule of hydro-cleaning the drains in the Dietary Department, and this process had been omitted for approximately 18 months. This process was reinstated effective 5/19/15, and a routine semi-annual schedule for hydro-cleaning the drains has been implemented. Should the semi-annual hydro cleaning schedule fail to maintain clear drains, a more frequent schedule will be developed. **Monitoring Process:** All Drain Cleaning Vendor Invoices shall be reviewed quarterly by the QA Committee to identify trends to modify cleaning schedule as indicated. Maintenance Director and Administrator shall ensure compliance. **F465(2)** **Immediate Correction:** The two identified screens were repaired on 5/26/15 by the Maintenance Department. The third screen identified as having a bent frame was repaired on 6/9/15. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Maintenance Director inspected all screens in Facility.	6/12/15 and ongoing 5/26/15 and 6/9/15 6/1/15

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F 371	Continued From page 9 several salad bowls and a dessert bowl. Between 11:56 a.m. and 12:10 p.m., both DA 1 and 2 were observed as they went back and forth to different walk-in refrigerators and walk in freezers, touched door handles and returned, with their ungloved hands unwashed, to the tray line. According to the FDA 2013 Food Code-Chapter 2:Management and Personnel-When to Wash "Food employees shall clean their hands and exposed portions of their arms... immediately before engaging in food preparation...and after engaging in other activities that contaminate the hands."	F 371	No other screens were identified as having tears, holes, or bent frames. **Monitoring Process:** Maintenance Director shall inspect Facility window screens on a monthly basis and record results of inspections. Screens identified as having tears, holes or bent frames shall be repaired as necessary.	6/12/15 and ongoing
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to maintain: 1. A functional plumbing system in the kitchen; and 2. Intact window screens for 3 resident windows. These failures had the potential to cause a multi-system failure in the kitchen, and increased the potential risk of unwanted pests near residents. Findings: 1. During the Initial Kitchen Tour on 5/19/15	F 465	**F514** **Immediate Correction:** The Charge Nurse interviewed Resident 14 approximately one hour after the administration of the pain medication. When the Charge Nurse went to document the PRN results, the Surveyor was reviewing the MAR binder. The Charge Nurse did not feel comfortable to approach the Surveyor to request the MAR in order to document the effectiveness of the PRN Medication administered to Resident 14, and subsequently forgot to go back and document it when the Surveyor had finished with the MAR binder. Upon the Surveyor bringing it to the attention of the Charge Nurse, she immediately documented the result of the PRN as a late entry.	5/20/15

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	056158	A. BUILDING _____ B. WING _____	05/22/2015

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F 465	Continued From page 10 started at 7:45 a.m., the air gap (unobstructed vertical space between the water outlet and the flood level of a fixture) under the counter, to the right of the prep sink, was noted to have pooled water in the drain. There was approximately 1 to 2 inches of water inside. In a concurrent interview with the Food Services Supervisor (FSS) on 5/19/15 at 7:45 a.m., she acknowledged the water in the drain and stated, "I'll call the plumber. It's happened before." At approximately 4:30 p.m., on 5/19/15 the Department was informed that two kitchen floor drains were backed up. A clogged drain was backed up with brownish-orange liquid. The drain, located to the right of the stove top oven, had been used to dispose of grease and fat. This caused the sloped floor drain, located approximately 3 feet diagonally across from the grease drain and approximately 2 feet across from the prep sink, to back up. The sloped floor drain had brownish water pooled around it, approximately 1 foot in circumference. At 4:40 p.m. on 5/19/15, the facility had already moved the steam table into the adjoining dining room. The Administrator and the Registered Dietician discussed whether or not the prepared dinner temperatures could be maintained, as the facility recognized they did not have a 240 volt electrical outlet plug for the steam table. Food temperatures were taken. The vegetables were measured at 160 degrees Fahrenheit and the pureed fish was measured at 130 degrees Fahrenheit. The facility implemented it's emergency food menu for dinner.	F 465	**Identification of Other Residents Having the Potential to be Affected:** The Director of Nursing and Administrator reviewed all PRN MARs to verify that all PRN medications had results charted within one hour of administration. There were no other Residents identified as having PRN Charting untimely or omitted. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** All Nursing Staff were inserviced with regards to PRN Documentation and also to not allow normal workflow to be impeded by Surveyors, that Nurses may request Resident Records from Surveyors in order to perform their duties timely. **Monitoring Process:** PRN Documentation is reviewed monthly by the Pharmacist Consultant. Pharmacist Consultant documentation and recommendations are reviewed quarterly by the Pharmaceutical Service Committee and QA Committee.	5/21/15 5/22/15 6/9/15 and ongoing 6/1/15 and ongoing

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F 465	Continued From page 11 A review of the plumbing invoices for September 2014, January 2015, and March 2015 revealed the following; 9/5/14-"Multiple floor drains backed up...cleared of grease" 1/27/15- "Dishwasher drain in kitchen backed up." 3/19/15- "Found kitchen floor drains backed up...cleared line of heavy grease from cleanout in front of rinse station...recommend general Jett line (high power flushing of line)." According to the US Food and Drug Administration, Food Code 2009, Chapter 5 Water, Plumbing and Waste, "Backflow Prevention...Improper plumbing installation or maintenance may result in potential health hazards such as cross connections, back siphonage or backflow. These conditions may result in the contamination of food, utensils, equipment, or other food-contact surfaces. It may also adversely affect the operation of equipment such as warewashing machines. Grease Trap-Failure to locate a grease trap so that it can be properly maintained and cleaned could result in the harborage of vermin and/or the failure of the sewage system." In an interview with the Management Supervisor on 5/19/15 at 5:18 p.m., she stated, "I've seen this happening before, but not this bad. Usually the FSS will tell me when it's (the grease drain) is backing up a little and I call the plumber...No one told me about the drain this morning." 2. During an Environmental Tour with a staff management person on 5/21/15 at 10:30 a.m., three window screens for resident rooms displayed small openings and tears through which	F 465		

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F 465	Continued From page 12 insects and flies could enter the facility. Two of the window screens contained a small hole approximately 1/2 inch by 1/2 inch in diameter, while the screen for the third room contained a one to two inch separation along the upper inner border of the screen where flies and insects could enter the facility. In a concurrent interview with the Director of Maintenance on 5/21/15 at 10:30 a.m., she acknowledged the damaged screens and stated she had not inspected the window screens recently.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the effectiveness of pain medication given on as needed basis was documented for 1 of 20 sampled residents (Resident 14). This failure had	F 514		

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F 514	Continued From page 13	F 514		

the potential to impact Residents 14's continuous assessment of pain.

Findings:

According to the admission record, Resident 14 was admitted to the facility with multiple diagnoses that included chronic pain syndrome and neuropathic (nerve) pain.

During a Medication Administration Observation on 5/20/15 started at 7:34 a.m., Resident 14 verbalized a pain intensity level of 10 out of 10 (10 equals severe pain) to Licensed Nurse (LN) 1. When LN 1 asked Resident 14 where the pain was, Resident 14 said her back and left leg. LN 1 then administered [brand name pain medication] (also known as hydrocodone-acetaminophen) 10/325 milligram (mg) 2 tablets by mouth to Resident 14 at 7:50 a.m.

A review of Resident 14's physician orders included an order for [brand name pain medication] 10/325 mg 2 tablets by mouth every 6 hours PRN (as needed) for severe pain.

A review of the back of Resident 14's Medication Administration Record, titled "Nurses Medication Notes," on 5/20/15 at 12:40 p.m., reflected LN 1 had not documented the effectiveness of the pain medication given to Resident 14, over 4 hours after she had given it.

A review of the undated facility policy titled "PRN Medication Documentation" stipulated, "...Within one (1) hour, the result of the PRN medication shall be charted by the nurse on the back of the MAR. If the PRN is for complaint of pain, the nurse shall document the pain score prior to

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F 514	Continued From page 14 giving the medication and within one hour after administration of the pain medication." During an interview and concurrent MAR review with LN 1 on 5/20/15 at 12:45 p.m., when LN 1 was asked about the missing documentation of the effectiveness of the pain medication given to Resident 14, LN 1 stated, "Oh, I forgot to document." During an interview with the Director of Nursing (DON) on 5/20/15 at 5:50 p.m., the DON was asked what her expectations were on documentation of the effectiveness of PRN pain medications. The DON stated, "...within 45 minutes to 1 hour..."	F 514		