STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555348	A. BUILDING _____ B. WING _____	06/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS CARE CENTER	3565 E. IMPERIAL HWY. LYNWOOD, CA 90262

(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 Re-certification Survey and Complaint Investigation visit. Complaint Intake #: CA00271867 - Substantiated Representing the Department of Public Health: [redacted], RN, HFEN [redacted], RN, HFEN [redacted], RN, HFEN Total Resident Census: 83 Total Resident Sample Size: 17 Highest Scope and Severity: E	F 000	F 000 - This plan of correction serves as my credible allegation of compliance. The facility will be in substantial compliance no later than 07/11/2011. Royal Oaks Survey completed on 06/10/2011	
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 failed to ensure that residents may self-administer medications if the interdisciplinary team (IDT) has determined this practice is safe for 1 of 17 sample residents (2) and one randomly selected resident (19). Resident 2 had a medication cup with all his morning medications at bedside. Resident 19 had three bottles of over-the-counter medications on	F 176	SELF-ADMINISTER DRUGS IF DEEMED SAFE It is the policy of this facility to ensure that residents who prefer to self-administer medications, is determined by inter-disciplinary team (IDT) to have the capacity to safely self administer medications. 1. Resident 2 had a care plan meeting with the IDT and was referred to the primary physician. Physician's orders were carried out accordingly. Completed on 06/17/11. 2. All facility residents with preference for self-administration of medication were scheduled for a care plan meeting with the IDT, and were referred to their primary physician. Physician's orders are carried out as ordered. Completed on 06/17/11. Residents capacity to safely self administer medications will be assessed by the IDT on a quarterly basis and as needed.	

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HEALTH FACILITIES
INSPECTION DIVISION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/2/2011

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 his bedside table. This deficient practice has the potential for the residents to take medications in an unsafe manner. Findings: 1. During an observation on 6/11/11, at 10:15 a.m., Resident 2 was in his room, sitting in his wheelchair. There was a medication cup on the over-bed table with several medications. The resident stated he would take the medications later, but was not able to identify what medications were in the cup. The resident indicated he had blurred vision and could not see well. The treatment nurse, who entered the room at the time of the observation, stated the cup contained the resident's morning medications. A review of the resident's record indicated he was admitted on 10/3/08, with diagnoses including hypertension (high blood pressure), diabetes mellitus, and glaucoma. There was no documented evidence the resident had been assessed for self-administration of medications. There was no physician's order for the resident to self-administer his medications. On 6/11/11, at 10:25 a.m., during an interview, a Registered Nurse (RN) supervisor stated medications should not be left at the bedside and the medication nurse had to make sure the resident swallowed his medications before leaving room. The RN also stated the resident was not able to self-administer medications due to his eyesight problems.	F 176	3. DON or designee will conduct random QA rounds of residents that self administer medication to ensure safety and compliance. All findings will be reported to the Administrator and IDT. The Pharmacy Consultant and DON in-serviced all licensed staff regarding the facilities policy on residents who self administer their own medication. Completed on 06/24/2011 and to be conducted quarterly thereafter. 4. The DON will report findings of QA rounds on self medication administrating residents to the QA committee on a quarterly basis and as needed.	6/14/11

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F 176	Continued From page 2	F 176		

On 6/11/11, at 10:30 a.m., during an interview, the medication nurse stated she left the medications in the resident's over-bed table because she was busy.

The facility's undated policy and procedure on Self-administration of Medications indicated the IDT will assess the safety of the resident self-administering his or her own medication.

The facility's undated policy and procedure on Medication Administration indicated to ensure the resident has enough fluids to swallow his or her medication and never leave medication at the bed side.

2. On 6/9/11, at 6:40 p.m., during the initial tour of the facility, Resident 19 was observed lying in bed watching TV. The resident's bedside table had multiple personal items and three bottles of over-the-counter medications, one bottle of Iron supplement, one bottle of Vitamin C and one bottle of Calcium-Magnesium-Zinc.
On 6/11/11, at 11:00 a.m., the same three bottles of over-the-counter medications were observed again on top of the resident's bedside table. The resident stated he took one tablet of each medication every couple days.
On 6/10/11, a review of the medical record revealed an initial admission to the facility dated 6/16/04, and a readmission dated 1/13/11, with diagnoses that included psychosis, depression, and right sided weakness.
The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/3/11, indicated the resident required limited assistance

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F 176	Continued From page 3 with activities of daily living activities. Further record review revealed no physician's orders for self-administration of the above mentioned over-the-counter medications. A self-administration of medication assessment dated 2/15/07, revealed the resident was not a candidate for safe self-administration of medications. On 6/11/11, at 11:30 a.m., during the interview, a RN supervisor stated the resident was assessed by the IDT for self-administration of medication and determined he was not a candidate due to poor eyesight and diagnosis of psychosis. The RN also stated she was not aware the resident had three bottles of medications on his bedside table. The undated facility's policies and procedure on Self-Administration of Medications indicated staff was to ensure that a resident may self-administer medication if the IDT determined that this practice is safe.	F 176	F226 , 48S.13(c) DEVELOPMENT ABUSE/NEGLECT, ETC POLICIES It is the policy of this facility to implement written policy and procedures and protect the resident from being in contact with the alleged perpetrator during the investigation of an alleged abuse. 1. Resident 1 condition was evaluated, and careplan was reviewed by the IDT and referred to the primary physician. CNA #1 was reassigned to ensure that there will be no contact with resident 1, Completed on 06/17/11. 2. DON conducted a general in-service on 06/22&24/2011 to all staff of the facilities policy and procedure on abuse and incidents. Any incidents or abuse allegation were reviewed by the Administrator and the IDT to ensure compliance. Completed on 06/17/11. 3. The facilities policy on abuse and incidents will be included in resident council meeting on a quarterly basis. All allegations of abuse will be reported to the Administrator or designee to ensure compliance. 4. Administrator will review with QA committee all allegations of abuse on a quarterly basis.	6/24/11
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement written policy and procedures on abuse for one of 17 sample residents (1). Resident 1 was not protected from being in contact with the alleged perpetrator during the investigation of an alleged abuse. This deficient	F 226		

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F 226	Continued From page 4	F 226		

practice caused the resident to be upset about seeing the staff member in her room the following day.

Findings:

On 6/9/11, at 7:15 p.m., during an interview with Resident 1, who was alert and oriented, she stated that on 6/8/11, Certified Nursing Assistant 1 (CNA 1) roughly handled her while repositioning her in bed. The resident further stated she immediately notified a supervisor of the CNA's rough handling.
Resident 1 also stated that the day after the incident, 6/9/11, the CNA went in her room to deliver a food tray.

A review of the resident's clinical record revealed an admission to the facility dated 6/6/11, with diagnoses that included acute renal insufficiency, diabetes and congestive heart failure.
The nursing admission assessment indicated the resident was oriented, was able to communicate her needs and required assistance with transfers and personal hygiene.

According to the facility's Elder/Dependent Adult Abuse policy and procedure revised on 5/23/11, when conducting an abuse investigation, immediately reassign any involved employee to duties that do not involve resident contact. Assignment will not be in a part of the facility that the resident normally frequents.

On 6/11/11, at 8:45 a.m., during an interview, the administrator stated he was the abuse coordinator for the facility, but the investigation and interviews were conducted by the Director of

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F 226	Continued From page 5 Staff Development (DSD). During an interview on 6/11/11, at 9:15 a.m., the DSD stated the CNA should not have been in the resident's room because that could make the resident feel uncomfortable. On 6/13/11. at 9:14 a.m., during an interview, CNA 1 stated that on 6/8/11, he assisted Resident 1 to use the bed and the resident told him he had hurt her. CNA 1 further stated he told her he was sorry that it was not his intention to hurt her and had not done it on purpose. When the resident complained to a supervisor, he was removed from the assignment. The next day, 6/9/11, the DSD instructed him to pass the food trays, what was not told not to go into Resident 1's room. CNA 1 stated when he went inside the room with the food tray the resident yelled at him to get out of her room.	F 226	F 241 483.115(a) DIGNITY AND RESPECT OF INDIVIDUALITY It is the policy of this facility to promote care in a manner that maintains and enhance the resident's dignity. 1. Resident 1 condition was evaluated, and careplan was reviewed by the IDT and referred to the primary physician. CNA #1 was reassigned the next day to ensure that there will be no contact with resident 1. CNA 1 was counseled about the facilities policy to treat resident with care, dignity and respect. Completed 06/10/11. 2. DON conducted a general in-service to all staff of the facilities policy and procedure on treating residents with, care, dignity and respect, all staff were informed of the consequence regarding anyone's failure to strictly adhere to this policy. Any incidents or complaints will be reviewed by the DON and the IDT to ensure compliance. Completed on 06/22&24/2011. 3 The facilities policy on treatment with care, dignity and respect as well as residents grievances, will be included in the resident's council meeting on a quarterly basis. All complaints and grievance will be reviewed by the DON or designee with the IDT to ensure compliance. 4. DON will review with QA committee all complaints and grievance on a quarterly basis and as needed.	6/24/11
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to promote care in a manner that maintained and enhanced the resident's dignity for 1 of 17 sample residents (1). Resident 1 complained Certified Nursing Assistant 1 (CNA 1) roughly handled her while	F 241		

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F 241	Continued From page 6 repositioning her in bed. This deficient practice caused the resident to feel upset and sad about the way CNA 1 treated her. Findings: On 6/9/11, at 7:15 p.m., Resident 1 was observed sitting in bed, was alert, oriented, and was able to verbalized her needs. The resident stated on 6/8/11, she was roughly handled by the CNA 1 while he moved her in bed. The resident stated CNA 1 lifted her too fast and pulled her body up in the bed roughly. She further stated she was upset, sad and immediately notified a supervisor of the incident. A review of the resident's clinical record revealed an admission to the facility dated 6/6/11, with diagnoses including acute renal insufficiency, diabetes, and congestive heart failure. The nursing admission assessment indicated the resident was oriented, was able to communicate her needs and required assistance with transfers and personal hygiene. A plan of care dated 6/7/11, developed for the resident's alteration in comfort/pain due to complaints of pain all over the body, included in the approaches to maintain good body alignment, and gently handle affected areas and position to comfort. During an interview on 6/11/11, at 8:45 a.m., with the administrator, he stated an investigation was conducted by the Director of Staff Development (DSD). On 6/11/11, at 9:15 a.m., during an interview, the	F 241		

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F 241	Continued From page 7 DSD stated all CNAs are to carefully handle the residents when assisting them with any activity of daily living. On 6/13/11, at 9:14 a.m., during an interview, CNA 1 stated on the morning on 6/8/11, he assisted the resident with using the bedpan and was told by the resident he had hurt her. CNA 1 stated he apologized and informed the resident it was not his intention to hurt her.	F 241	F 253 483.1E(n)(2) HOUSEKEEPING & MAINTENANCE SERVICES It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a functioning, sanitary, orderly, and comfortable interior. Findings 1. a) The two fans of the laundry room were cleaned by the housekeeping staff on 06/12/11. b) The screen door in the laundry room leading to the outside of the building was repaired by the maintenance staff on 06/13/11. c) The light above the entrance door of shower room 2 were replaced by the maintenance staff on 06/12/11. d) Rooms 5, 10 and 34 call light reset bulb and protective cover were replaced by the maintenance staff on 06/15/11. e) Rooms 14 and 15 bathroom tissue dispensers were placed by the maintenance staff on 06/17/11. f) Rooms 21 and 25, the light reset bulb were repaired by the maintenance staff on 06/17/11.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & 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 interviews, the facility failed to provide housekeeping and maintenance services necessary to maintain a functioning, sanitary, orderly, and comfortable interior. Findings: 1. During a general environmental inspection of the facility on 6/9/11, from 7:40 p.m. to 8 p.m., in the presence of the housekeeping supervisor, the following was observed: - The laundry room had two fans covered with lint. One of the fans, located above the washing machine was operating and was facing a blue bin containing clean linens. The other fan, which was facing an opened clean	F 253		

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F 253	Continued From page 8 linen cabinet, was next to a door that had the screen open and the air was blowing from the outside towards the opened cabinet. - The screen door in the laundry room leading to the outside of the building had two holes that measured two inches in width and one inch in length. The holes in the screen door would not protect from dust and small animals entering the laundry room. - Shower Room 2 had a non-functioning light above the entrance door. The light did not function when the call lights on the three stalls were turned on. At the time of the observation, the housekeeping supervisor stated the light bulb above the shower room door needed to be replaced. 2. During an environmental inspection of the residents' rooms conducted on 6/10/11, from 7:20 p.m. to 7:50 p.m., with the housekeeping and maintenance services supervisors, the following was observed: - In Rooms 5 and 34, the call light reset bulb did not have a protective cover. - In Room 10, the call light reset button had a missing bulb and missing protective cover. - In Rooms 14 and 15, the tissue dispenser in the bathroom had no cover. - In Rooms 21 and 25, the call light reset bulb was not working.	F 253	g) Room 26 bed C call lights was repaired by the maintenance staff 06/17/11. 2. The maintenance supervisor conducted a full facility inspection of all fans, screen doors, call lights, bathroom tissue dispensers and lights, all findings will be reported to the administrator and cleaned, repaired or replaced as needed. All facility staff were inserviced by the maintenance supervisor regarding the facilities policy to provide maintenance and housekeeping services, and that part of the employees responsibility to report any areas, utilities or equipment that needs cleaning or repair. The staff was also reminded that a maintenance communication log is available at the nurse station to report their findings. Completed on 06/22/11. 3. The maintenance supervisor will conduct random QA rounds to ensure compliance. 4. The Administrator or designee will review with QA committee all findings of QA rounds on a quarterly basis and as needed	6/22/11

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F 253	Continued From page 9 - In Room 26, one of the call lights (in Bed C) was malfunctioning. During an interview on 6/10/11, at 7:50 p.m., the maintenance supervisor stated the missing/malfunctioning reset bulbs and protective covers would be replaced. On 6/10/11, at 7:52 p.m., during an interview, the housekeeping supervisor stated the tissue dispensers in Rooms 14 and 15 would be replaced.	F 253	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING It is the policy of this facility to ensure each resident receives care and services in accordance with the comprehensive assessment and plan of care. 1. Resident 17 and responsible party were invited for a careplan meeting with the IDT staff; careplan was reviewed and primary physician was informed and implemented accordingly. Completed on 06/15/11. 2. RN # 1 was in-serviced by the DON and Pharmacy consultant regarding the facilities policy to ensure that each resident receives care and services according to the comprehensive assessment and plan of care. Emphasis was placed on the necessity to inform the family, the physician and the DON about any changes of condition of the patient including refusal of a treatment or medication prior to change of service. Completed on 06/24/11. 3. All licensed nurses were in-serviced by the DON and Pharmacy consultant regarding the facilities policy to ensure that	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident receives care and services in accordance with the comprehensive assessment and plan of care for 1 of 17 sampled residents (17). Resident 17, who was confused and was admitted to the facility with a peripherally inserted central catheter (PICC) line on the right arm for intravenous (IV) administration of antibiotics, was inserted an additional IV catheter because the resident did not extend the right arm to allow the IV administration of antibiotic. This failure caused the resident to undergo repeated,	F 309		

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F 309	Continued From page 10 unnecessary insertion of another IV catheter. Findings: According to a complaint, Resident 17 underwent unnecessary insertion of an IV catheter when the resident had a PICC line inserted in a acute hospital for IV antibiotic therapy. A closed clinical record review revealed Resident 17 was admitted on 6/2/11, from an acute hospital with diagnoses that included dementia, pneumonia, chronic obstructive pulmonary disease (COPD), asthma, and status post PICC line placement on the right arm for intravenous antibiotics. The admission assessment dated 6/2/11, at 6 p.m., indicated the PICC line on the right arm was intact with no sign and symptoms of infection. The physician's admission orders indicated to give IV antibiotic therapy with Zithromax 500 milligrams (mg) every 24 hours for three days starting on 6/3/11, and Ceftriaxone one gram (gr) every 24 hours for five days starting on 6/3/11. The physician also ordered to assess the site of the PICC line on the right arm every eight hours and document. A physician's order was obtained on 6/3/11, at 8 a.m., for an insertion of a heplock (peripheral IV) on the left arm because the resident refused to extend the right arm for the IV therapy. According to a nurse's note dated 6/3/11, at 8 a.m., the resident was cooperative during the placement of the heplock on the left hand,	F 309	each resident receives care and services according to the comprehensive assessment and plan of care. Emphasis was placed on the necessity to inform the family, the physician and the DON about any changes of condition of the patient including refusal of a treatment or medication prior to change of service. Completed on or before 06/24/11. DON will conduct random QA rounds of medication pass and treatment to ensure compliance. 4. DON will review with QA committee all QA rounds findings on a quarterly basis and as needed.	6/24/11

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F 309	Continued From page 11 continued to refuse having the right arm touched, and tolerated the IV antibiotic infusion via the left hand heplock. On 6/11/11, at 10 a.m., during an interview, Registered Nurse 1 (RN 1) stated she attempted three times to encourage the resident to extend the right arm which had the PICC line for the IV antibiotic infusion. When the resident continued to refuse and covered her arm with a blanket, she spoke with the on-call physician's assistant (PA) and obtained an order to place a peripheral IV on the other arm. RN 1 stated she did not call the family/responsible party to request for assistance in obtaining cooperation from the resident. RN 1 did not have another staff member attempt to get the resident's cooperation. RN 1 did not inform the resident's responsible party about the insertion of another IV line. RN 1 further stated that once a family member spoke with the resident, she allowed the use of the PICC line. There was no documented evidence the RN attempted alternative measures to gain cooperation from the resident for the antibiotic administration through the PICC line.	F 309	F 312. 483.26(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS It is the policy of this facility to ensure that appropriate care and services are provided to residents who require assistance with their activities of daily living in the areas of grooming and personal hygiene. 1. Resident 2's careplan was reviewed and implemented accordingly. Completed on 06/17/11. The CNA's assigned to resident 2 on 06/09/11 – 3pm to 11pm, 06/10/11 - 3pm to 11pm and 06/11/11 - 7am to 3pm were in-serviced by the DSD on 06/22&24/2011 regarding the facilities policy to ensure that appropriate care is provided to residents who require assistance with their activities of daily living in the areas of grooming and personal hygiene. 2. All CNA's were in-serviced by the DSD regarding the facilities policy to ensure that appropriate care is provided to residents who require assistance with their activities of daily living in the areas of grooming and personal hygiene. Completed on 06/24/11.	
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	F 312		

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F 312	Continued From page 12 by: Based on observation, interview, and record review the facility failed to ensure appropriate care and services were provided to a resident who needed assistance with his activities of daily living in the areas of grooming and personal hygiene for 1 of 17 sampled residents (2). Resident 2 was wearing a pair of soiled sweat pants for three consecutive days. Findings: During observations on 6/9/11, at 8:00 p.m., on 6/10/11, at 4:55 p.m., and on 6/11/11, at 8:30 a.m., Resident 2 was observed wearing a pair of gray sweat pants visibly soiled with food particles. During an interview on 6/11/11, at 8:30 a.m., the resident stated that he was unable to see what he was wearing due to his eyesight problems and he was only able to see black shadows. He further stated he did not like wearing dirty clothes and he needed assistance from staff for dressing. A record review revealed the resident was admitted to the facility on 10/3/08, with diagnoses that included high blood pressure, diabetes, glaucoma and old cerebrovascular accident. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 4/29/11, indicated that the resident had range of motion limitations and required assistance from staff for dressing, hygiene and bathing. An Activities of Daily Living care plan dated 4/29/11, indicated that the goal was for the resident to be well groomed, clean, and dry daily. The approaches included to assist the resident and to encourage him to stay neat and clean.	F 312	3. DON and DSD will conduct random QA rounds during provision of care and services to residents, as well as conduct checks of resident hygiene to ensure compliance. 4. DON will review with QA committee all QA rounds findings on a quarterly basis and as needed. F 328 483.25(k) TREATM IT/CARE FOR SPECIAL It is the policy of this facility to ensure that residents receive proper respiratory Care treatment as ordered by the physician. 1. Resident 7 and 13 care plan's were reviewed and condition was evaluated by the DON and the IDT and referred to the primary physician, careplan was revised as needed and implemented to ensure that resident receives the prescribed rate of oxygen to meet the patients needs, and humidifier bottles and tubing's are labeled according to the facilities policy and procedure. Completed on 06/17/11. 2. All resident's requiring respiratory care were reviewed and their conditions were evaluated by the DON and the IDT and referred to their primary physician, their careplans were revised as needed	6/24/11

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F 312	Continued From page 13 On 6/11/11, at 10:35 a.m., during an interview, the Director of Staff Development (DSD) stated the Certified Nursing Assistants (CNAs) were to encourage the residents to make decisions on what kind of clothing they want to wear and made sure it was weather appropriate. She further stated that if the resident's clothing was soiled the CNAs had to change the resident's clothing right away.	F 312	and implemented to ensure that resident receives the prescribed rate of oxygen and other respiratory care services to meet the patients needs as per facilities policies and procedures. Completed on 06/17/11. All licensed nurses were in-serviced 6/22&24/2011 by the DON and DSD regarding the policy of this facility to ensure that residents receive proper respiratory care treatment as ordered by the physician, and implement the services according to facilities policies and procedures. Completed on 06/24/2011.	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents receive proper respiratory care treatment for 2 of 17 sample residents (7,13). Residents 7 and 13 did not receive oxygen as ordered by the physician. Findings: 1. A review of Resident 7's clinical record review	F 328	3. DON or designee DSD will conduct random QA rounds during of residents receiving respiratory care to ensure compliance with physician's orders and facilities policies and procedures. 4. DON will review with QA committee all QA rounds findings on a quarterly basis and as needed.	6/24/11

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F 328	Continued From page 14 revealed she was admitted to the facility on 5/19/11, with diagnoses that included acute congestive heart failure and chronic obstructive pulmonary disease (COPD). Th Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/1/11, indicated the resident was able to understand others and be understood, and required limited assistance with activities of daily living activities (ADLs). A physician's order dated 5/19/11, indicated oxygen at 2 liters per minute via nasal cannula continuous for shortness of breath. On 6/9/11, at 7:20 p.m., during the initial tour, and on 6/10/11, at 4:30 p.m., the resident was observed lying in bed with oxygen at three liters per minute via nasal cannula. The humidifier bottle and the oxygen tubing had no label indicating the date they were changed. On 6/10/11, at 5:47 p.m., during an interview, a licensed nurse had no explanation why the oxygen flow rate was not administered as the physician had ordered. 2. A review of Resident 13's clinical record revealed the resident was readmitted to the facility on 2/15/11, with diagnoses that included coronary artery disease (a narrowing of the small blood vessels that supply blood and oxygen to the heart), and diabetes. The MDS dated 6/2/11, indicated the resident required total assistance with all activities of daily living. A physician's order dated 2/15/11, indicated oxygen at two liters per minute via nasal cannula. However, on 6/9/11, at 7:55 p.m., the resident	F 328		

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F 328	Continued From page 15 was observed lying in bed with oxygen at 2.5 liters per minute via nasal cannula. The facility's policies and procedures titled "Oxygen Administration" revealed humidifier bottles and oxygen tubing should be replaced every seven days. Humidifier bottles need to be dated, and oxygen flow rate should be on as the prescribed amount.	F 328	F 333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS It is the policy of this facility to ensure that residents are free from any significant medication errors. 1. Residents 18 & 20 were referred to their primary physicians and careplans were reviewed by the DON and IDT and implemented accordingly. Medication nurse assigned to resident 18 and 20 was in-serviced by the DON and Pharmacy Consultant regarding the facilities medication administration policy and procedure. Completed on 06/24/2011. 2. All residents on GT feeding and all diabetic patients medications were audited by the DON or designee for accuracy of medication pass and referred to their primary physician as needed. All licensed nurses were in-serviced by the DON regarding the facilities medication administration policy and procedure and scheduled with a follow-up in-service by the pharmacy consultant. Completed on 06/24/11. 3. DON or designee will conduct random medication pass QA rounds to ensure compliance. Pharmacy consultant will conduct medication pass QA	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents are free of any significant medication error for two randomly selected residents (18, 20). Residents 18 did not receive a complete dose of the medication Diltiazem Hydrochloride. Resident 20 did not receive the hypoglycemic medication Metformin. This deficient practice has the potential for complications from inadequate treatment of a disease. Findings: 1. On 6/9/11, at 8:20 p.m. during a medication pass observation, the medication nurse was observed pouring Diltiazem Hydrochloride via gastrostomy tube (GT), particles of the medication were left remaining in the medication cup.	F 333		

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F 333	Continued From page 16 A review of the clinical record revealed the resident was readmitted to the facility on 5/13/10, with diagnoses that included diabetes, hypertension, and status post gastrostomy tube. A physician's order dated 5/3/10, indicated the administration of Diltiazem Hydrochloride 60 milligram (mg) tablet via GT every 8 hours for hypertension. During an interview on 6/11/11, at 9:30 a.m., with the Director of Staff Development (DSD) she stated that when medication is given via GT, the nurses are to make sure the medication has completely dissolved and no residuals are left in the medication cups. The undated facility's policy and procedure on Tube Administration (Nasogastric, Gastric, and Jejunostomy) indicated to rinse the medication cup and administer rinsing to assure complete dose. 2. On 6/10/11, at 5:15 p.m., during the medication observation pass for Resident 18 revealed the licensed nurse did not administer Metformin to the resident. On the same day, at 7:00 p.m., during a medication reconciliation, a review of the clinical record revealed the resident was readmitted to the facility on 8/14/10 with diagnoses that included depression and diabetes. A physician's order dated 4/30/11, indicated Metformin Hydrochloride 1, 000 mg by mouth twice a day with meals for diabetes.	F 333	rounds on a quarterly basis and provide in-services on medication pass as needed. 4. DON will review with QA committee all QA rounds findings on a quarterly basis and as needed	6/24/11

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F 333	Continued From page 17 On the same day, at 9:00 p.m., during an interview, the licensed nurse who administered the resident's medication acknowledged she forgot to give the tablet of Metformin to the resident. The licensed nurse stated she got interrupted by other staff member during the medication pass. The facility's policies and procedure on Medication Administration indicated staff was to assure residents receive the ordered medication in a timely manner.	F 333	F 365 483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS It is the policy of this facility to ensure the menu had a variety of food choices according to the resident's food preferences. 1. The menu was referred to the Registered Dietitian consultant for review and revision to meet resident request and needs. The policy for menu replacement was also referred to the RD consultant for review. Completed on 06/30/11. 2. A questionnaire was developed by the dietary supervisor to randomly inquire the residents about the food provided by the dietary department on a weekly basis. Completed by 07/10/11. 3. Menu and food quality will be included in the monthly resident's council meeting. Dietary supervisor will conduct random QA rounds during meals to inquire about the resident's comments and suggestion about the food choices. 4. Dietary supervisor will review with QA committee all QA rounds findings on a quarterly basis and as needed.	7/10/11
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the menu had a variety of food choices according to the residents' preferences. Six out of nine residents in the group meeting complained they had to eat sandwiches for dinner four times a week. The dietary menu had not been changed for the past three years. This deficient practice has the potential for not meeting the residents' needs. Findings: On 6/10/11, at 5:30 p.m., during the group meeting interview, six out of nine residents in attendance, complained that they were tired of eating sandwiches for dinner. The residents stated that they have complained to the staff but	F 365		

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F 365	Continued From page 18 nothing has been done about it. A review of the planned menu for Spring, Summer, Fall, and Winter indicated sandwiches were served three to four times a week for the evening meal. On 6/11/11, at 1:30 p.m., after reviewing the menu, the dietary supervisor stated the dietitian planned the menu and the menu had not been revised for the past three years. The dietary supervisor also stated the facility did not have policies regarding how often the menu should be revised.	F 365		
F 371 SS=D	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 ensure food was stored and served under sanitary conditions. Food items stored in the refrigerators were not labeled and some items were expired. This deficient practice has the potential for serving food items that are no longer safe to be consumed by the residents placing the residents	F 371	F 371 483_35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY It is the policy of this facility to ensure that its food was stored and served under sanitary conditions, and food items stored in the refrigerators are labeled and served before the recommended date of expiration. 1. The dietary supervisor audited the refrigerator and checked the date of opening or preparation then labeled and dated the food items. All food in all storage were inventoried and checked for expiration. Any expired items are to be disposed of immediately. 2. All dietary personnel were inserviced by the Dietitian regarding the policy of the facility to ensure that its food was stored and served under sanitary conditions, and food items stored in the refrigerators are labeled and served before the recommended date of expiration. Completed on 06/3011. 3. Dietary supervisor will conduct random QA rounds of all food storage to ensure compliance. RD will conduct random QA rounds and provide inservice	

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F 371	Continued From page 19 at risk of foodborne illnesses. Findings: On 6/9/11, at 6:05 p.m. during the initial kitchen tour, in the presence of the cook, it was observed that food items were stored in the refrigerator and freezer with no labels indicating the opening date and their expiration date as follows: - Four cups of milk - Two cups of juice - One box of pasteurized cream cheese with no opening date and an expiration date of 5/14/11 - One unlabeled water bottle containing juice that according to the cook belong to one of the kitchen staff At 6:22 p.m., during an interview, the cook stated all food items should be labeled with the date and time they were opened. The facility's Infection Control for the Food Service Department policy and procedure dated 5/2006, indicated all opened food shall be labeled and dated.	F 371	regarding food handling practices and facility policy procedure. 4. Dietary supervisor will review with QA committee all QA rounds findings on a quarterly basis and as needed.	7/11/11