POC accepted
Alicia Henry, HFEN
8/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION B. WING	07/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEA REHABILITATION HEALTHCARE	7716 S PICKERING AVENUE WHITTIER, CA 90602

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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: [redacted], RN - HFEN [redacted], RN - HFEN [redacted] REHS - HFE I Total Resident Population: 97 Total Resident Sample: 20 Highest Scope and Severity: E	F 000	Shea Rehabilitation Healthcare Center makes its best effort to operate in full compliance with both Federal and State Law. Nothing included in this Plan of Correction is an admission otherwise. Shea Rehabilitation Healthcare Center has submitted this Plan of Correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of any allegations contained herein. Please note that Shea Rehabilitation Healthcare Center may contest the merits and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them.	
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 policies and procedures on abuse prevention by not conduct screening on three out of five new hired employees for a potential history of abuse. This deficient practice had the potential to hire individuals with history of abuse. Findings: According to an undated facility's policy and	F 226	**[F226] 483.13(c) DEVEOP / INPLAMENT ABUSE / NEGLECT, ECT POLICIES** **Corrective Action for Affected Residents** **Finding 1 & 2:** On or before August 11, 2012, the three identified employees were screened for potential history of abuse. None were noted to have had a history of abuse, neglect or mistreatment of residents. The one License Vocational Nurse license has been verified with the State Licensing Board and is in good standing.	8/11/2012

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

Richard Escontrias — Administrator — 8/10/2012

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 226	Continued From page 1 procedure on Prevention of Resident Abuse and Mistreatment, prior to hiring any employee, the facility shall ensure provisions covering employment screenings for potential history of abuse, neglect or mistreatment of residents. Once authorization to secure information has been obtained, it is the responsibility of the facility staff (i.e. administrator, department supervisors, etc.) to call at least one of the previous employers and current employers and inform them of the potential hiring of the employee. Licenses and certifications shall be verified before hiring by the director of nurses and director of staff development, respectively. On 7/21/12, at 3:10 p.m., a review of the personnel records of five new employees hired within the previous four months and who were already working in the facility was conducted with the director of staff development (DSD). Three of the five employee files were incomplete and lacked pre-employment screening. The file of a social service staff member, a licensed vocational nurse (LVN) and a certified nursing assistant (CNA) did not have evidence of reference check from previous or current employers. The LVN license had not been verified with the state licensing board. At the time of the review, the DSD stated that the administrator or the DSD are responsible to call the previous/current employers for screening and the DSD is in charge of the license verification before hiring.	F 226	**Corrective Action for Potentially Affected Residents** **Findings 1-2:** On or before August 11, 2012, under the supervision of the Administrator, the DSD has be in-serviced regarding the facility's policy and procedure prior to hiring any employee shall consider the prevision on screening for potential history of abuse, neglect or mistreatment of residents and calling current and previous employers prior to hiring any employee, also the DSD will be in served on License and Certification Board shall be verified before hire. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator, the facility will follow the policy and procedure on screening for potential history of abuse, calling current and previous employers and verified License and Certification with the License and Certification Board prior to hiring any employee.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		

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F 250	Continued From page 2 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically-related social services to assist a resident with hearing difficulties for one of 20 sample residents (12). Resident 12 was hard of hearing, did not use hearing aids and had no hearing evaluation. This deficient practice resulted in the resident having problems communicating with others. Findings: On 7/19/12, at 6:50 p.m., during the initial tour of the facility and an attempted interview, Resident 12 was observed lying in bed and was able to communicate, however, the resident stated she could not hear well and the speaker had to repeat each word loud and close to the resident's ear. A licensed nurse present at the time of the observation and the attempted interview explained the resident was hard of hearing. On 7/20/12, at 8:50 p.m., during the medication pass observation, the resident had difficulty understanding what the medication nurse was telling her. The medication nurse had to speak loud and repeat each word but the resident stated she could not hear and did not understand what the nurse was telling her.	F 250	**Measures Adopted for Systemic Change and Quality Assurance** On a quarterly basis, under the supervision of the Administrator the DSD or designee will present all reviews of all potential new hires will be presented to verify that the facility's policy and procedures screening, background checks and verified License and Certification of potential employee prior to hire. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary. **[F250] 483.15(g)(1) PROVISION OF MEDICALY RELATED SOCIAL SERVICES** **Corrective Action for Affected Residents** Resident 12 was referred in June, 2012 and this appointment is pending with the ENT/Audiologist for evaluation. Pending the results of the evaluation the facility will proceed as ordered by the physician. A communication board was given to resident to ease communication.	8/11/2012

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F 250	Continued From page 3 A review of the clinical record revealed the resident was readmitted to the facility on 10/21/11, with diagnoses that included dementia (progressive loss of memory and other intellectual function) and anxiety. The Minimum Data Set (MDS-standardized assessment and care planning tool) dated 5/2/12, indicated the resident had memory problems, had moderate difficulty in hearing (speaker has to increase volume and speaks distinctly) and had no hearing aid or other hearing appliance used. The resident was assessed as requiring limited to total assistance with activities of daily living (ADLs). There was no documentation the resident was seen by an audiologist (a trained professional who evaluates hearing loss). The social service notes from 10/29/11 to 6/8/12, did not address the resident's hearing deficit and did not indicate if there was a plan to refer the resident for a hearing evaluation. On 7/21/12, at 11 a.m., during an interview, the social service designee (SSD) stated she was not aware the resident had any hearing problems.	F 250	**Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the Administrator, the Social Service staff has been in-serviced the regarding providing medically-related social services to asst residents with hearing difficulties. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator or a designee, will observe and monitored for four weeks for three months, and then randomly. The Social Service staff will use a vender book to refer and track all pending medically-related social services and care plan as needed all medically-related social service referral. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DSD or designee will conduct unannounced observations to verify that the Social Services are use a vender book, to refer and tack all pending medically-related social services and as needed care plan all medically-related social service referrals. The results of such evaluations shall be	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comfortable	F 257		

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F 257	Continued From page 4 room temperature level for one of 20 sample residents (3). Resident 3's room temperature was 69.8 degrees Fahrenheit (F). This deficient practice resulted the resident having difficulty sleeping due to the cold environment. Findings: On 7/19/12, at 6:45 p.m., during the initial tour of the facility in the presence of Registered Nurse 1 (RN 1), Resident 3 was observed lying in bed covered with a sheet and a blanket. An air conditioning vent in the middle of the ceiling was blowing cold air directly on the resident. At the time of the observation, during an interview, the resident stated the room is very cold at night especially between 3 a.m. to 4 a.m. The resident complained that since he was admitted to the facility, he has a difficult time sleeping due to the low room temperature. The resident further stated he would get out of the bed at approximately 4 a.m. and go to the fireplace in the activity room to keep warm. Upon hearing the resident's statement, RN 1 responded by saying she would tell the maintenance personnel to adjust the room temperature. The resident replied he has been told by several other staff members that they would have the maintenance personnel adjust the room temperature but the maintenance personnel never came to check his room temperature or to adjust the temperature level. The resident pointed out how the curtain moved from the pressure of the blowing cold air. At 7:15 p.m., the room temperature was measured at 69.8 degrees F and not between 71 - 81 degree F range as required.	F 257	(continue) documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary. **[F257] 483.15(h)(6) COMFORTABLE AND SAFE TEMPATURE LEVELS** **Corrective Action for Affected Residents** The thermostat was adjusted to 72 degrees and the air condition vent was adjusted to direct the air flow evenly on 7/19/2012. Resident 3 moved to another room in the facility. **Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the Administrator the staff has been in-serviced regarding assuring and providing a comfortable and safe temperature levels between 71 - 81 degrees F.	8/11/2012

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F 257	Continued From page 5 A review of the clinical record revealed the resident was admitted to the facility on 6/15/12, with diagnoses that included brain mass (tumor), kidney cancer, status post chemotherapy treatment and currently receiving radiation therapy. The admission Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/21/12, indicated the resident was able to make his needs known and required supervision to extensive assistance in activities of daily living (ADLs).	F 257	**Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator, The Maintenance staff will monitor for four weeks for three months, and then randomly, the thermostats and interview residents to determine that the facility is providing a comfortable and safe temperature levels between 71 - 81 degrees F. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the Maintenance Supervisor or designee, will report all unannounced observations will be reported that verify the facility's implementation of its policy and procedures regarding assuring and providing a comfortable and safe temperature levels between 71 - 81 degrees F. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	
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 observation, interview and record review, the facility failed to provide the necessary care and services for eye dryness for one of 20 sample residents (5). Resident 5, who was unable to communicate his needs and kept his left eye open, had no treatment to prevent eye dryness and irritation and there was no documentation the nurses relayed this concern to the physician for further orders/interventions. This deficient practice had the potential to result in eye discomfort.	F 309		

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F 309	Continued From page 6 Findings: During observations conducted on 7/19/12, at 6:10 p.m., 7/20/12, at 5 p.m. and 8:20 p.m., and 7/21/12, at 8:15 a.m. and 11 a.m., Resident 5 was lying in bed on his right side, with his right eye closed and the left eye open and not blinking. There was some redness in the left eye. The resident was non-verbally responsive, had a tracheostomy (a tube surgically inserted into the trachea for purposes of airway access and removal of secretions) and was receiving oxygen via a tracheostomy collar. On 7/21/12, at 9:15 p.m. during an interview, Certified Nursing Assistant 1 (CNA 1) stated the resident rarely blinked. A review of the clinical record revealed the resident was admitted to the facility on 6/29/12, with diagnoses of end stage cancer of the throat and neck and acute respiratory failure with tracheostomy. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/19/12, indicated the resident was alert and required extensive to total staff assistance with all of his activities of daily living (ADLs). There was no physician's order for eye medications/treatment. There was no plan of care or nursing notes addressing the resident's open left eye, lack of blinking and presence of redness and the resident's risks to develop eye irritation and pain. There was no documentation the nursing staff relayed to the physician the resident's inability to close his left eye, lack of blinking and the	F 309	**[F309] 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Corrective Action for Affected Residents** **Finding 1:** On July 20, 2012 under the supervision of the DON, the resident physician and order for artificial tears was given. All other residents in the facility were evaluated for the similar eye condition. None were identified. **Corrective Action for Potentially Affected Residents** **Findings 1:** On or before August 11, 2012, the license nursing under the supervision of the DON, licensed nursing staff has been in-serviced regarding the importance of proper eye / visual assessments upon admission and as needed to prevent complications the resident's eyes. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the DON or designee, they will perform unannounced audits and observations for four weeks for three months, and then randomly, to verify that the proper eye / visual assessments upon admission and as needed to prevent complications the resident's eyes.	8/11/2012

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F 309	Continued From page 7 presence of redness on the eye. On 7/21/12, at 9:20 p.m., during an interview, the subacute unit clinical coordinator stated the resident should be receiving Artificial Tears as a comfort measure.	F 309	**Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DON or designee will perform unannounced audits will be conducted to verify that the proper eye / visual assessments upon admission and as needed to prevent complications the resident's eyes. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure necessary care and services for two of five sample residents with pressure ulcers out of 20 sample residents (8, 13). Resident 8, who had a sacrococcygeal (tail bone area) Stage III pressure sore (full thickness tissue loss), was lying on a LAL (low air loss mattress which reduces pressure on the body tissues) mattress over a wrinkled sheet which had the potential to result in further skin breakdown. For Resident 13, the treatment nurse did not follow the facility's policy on clean dressing change which had the potential to result in contamination and infection. Findings:	F 314	**[F314] 483.25(c) TREATMENT SERVICES TO PREVENT PRESSURE SORES** **Corrective Action for Affected Residents** On 7/19/2012 the DON adjusted the sheet removing the wrinkles. On or before August 11, 2012, under the supervision of the DON/ DSD, The treatment nurse was given one on one in service on proper hand washing procedure per the facilities policy and procedure.	8/11/2012

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F 314	Continued From page 8 1. On 7/19/12, at 7:30 p.m. during the initial tour, and on 7/20/12, at 5:25 p.m., Resident 8 was observed lying in bed on a LAL mattress over a wrinkled sheet that left marks on the resident's skin on the buttocks and back areas. A review of the clinical record disclosed the resident was admitted to the facility on 4/3/12, with diagnoses that included Stage III pressure sore of the sacrococcyx area, congestive heart failure and Parkinson's disease. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 4/10/12, indicated the resident was confused, was incontinent of bowel function, had an indwelling urinary catheter for wound management and required extensive staff assistance with her activities of daily living (ADLs). On 7/19/12, at 7:35 p.m., during an interview, the director of nursing stated the sheet should not be wrinkled to prevent further skin breakdown. 2. A review of Resident 13's clinical record disclosed the resident was readmitted to the facility on 4/18/12, with diagnoses which included acute respiratory failure, tracheostomy (tube surgically inserted into trachea/windpipe for purposes of airway access and removal of excess secretions), history of stroke, gastrostomy tube (GT - tube surgically inserted into the stomach through the abdominal wall for the purposes of nutrition and medication administration) and Stage III left buttock pressure sore. The MDS assessment dated 5/15/12, indicated the resident had moderately impaired cognition,	F 314	**Corrective Action for Potentially Affected Residents** On or before August 11, 2012 under the supervision of the DON/DSD, licensed nursing staff has been in-serviced regarding proper fitting of sheets on a low air loss mattress assuring that sheets on the residents' beds are not wrinkled. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator the DON/DSD or designee will monitor for four weeks for three months, and then randomly, the low air loss mattress sheets are proper fitted and assuring that the sheets are not wrinkled. DON/DSD or designee will randomly monitor the treatment nurse was given one on one in service on proper hand washing procedure per the facilities policy and procedure. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DON or designee will present the unannounced evaluations to verify that the facility's policy and procedures regarding that the low	

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F 314	Continued From page 9 was incontinent of bowel, had an indwelling urinary catheter for wound management, was dependent on the GT for feeding and was totally dependent on staff for all ADLs. On 7/21/12, at 9:45 a.m., during a treatment observation of the resident's GT insertion site and the left buttock pressure sore, the treatment nurse did not wash her hands between the removal of soiled gloves (used to remove the soiled GT dressing) and donning clean ones, did not use gloves during repositioning of the resident and did not wash her hands after repositioning the resident and before donning clean gloves to remove the soiled dressing over the buttock pressure sore. An undated facility's policy and procedure on Treatments stipulated to remove the old dressing, then remove gloves, wash hands, re-glove, and proceed with treatment order. On 7/21/12, at 10:30 a.m., during an interview, the treatment nurse acknowledged she should have washed her hands following the removal of the GT dressing and after repositioning the resident, in order to prevent wound contamination.	F 314	(continue) air loss mattress sheets are proper fitted properly. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary. **[F315] 483.25(d) NO CATHATER, PREVENT UTI, RESTORE BLADDER** **Corrective Action for Affected Residents** **Finding 1:** on 7/20/2012 the indwelling catheter was discontinues by the resident physician. **Corrective Action for Potentially Affected Residents** **Findings 1-2:** On or before August 11, 2012, under the supervision of the DON / DSD the license staff has been in-serviced regarding valid medical justification for a indwelling catheter and an explanation to the physician of the continued use of the indwelling catheter.	8/11/2012
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	F 315		

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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 315	Continued From page 10 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 an indwelling urinary catheter was not used unless there was a valid medical justification for one of 20 sample residents (4). Resident 4, who had a healed pressure sore, had an indwelling urinary catheter for skin management since admission. The interdisciplinary team determined the catheter was no longer needed but did not discuss it with the physician for discontinuation or further orders. This deficient practice had the potential for recurrence of urinary tract infection. Findings: On 7/19/12, at 6 p.m., during the initial tour, Resident 4 was observed lying in bed with an indwelling urinary catheter connected to a drainage bag hanging under the metal frame of the right side of the bed. A review of the clinical record revealed the resident was admitted to the facility on 5/24/10, and readmitted on 5/3/12, with diagnoses that included urinary tract infection (UTI), diabetes mellitus and paraplegia (paralysis of the lower extremities). According to the annual Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/5/12, the resident was able to communicate needs, did not walk, required	F 315	**Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator the DON / Medical Records or designee will monitor for four weeks for three months, and then randomly, the residents charts for valid medical justification for a indwelling catheter and an explanation to the physician of the continued use of the indwelling catheter. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DON and Medical Records or designee will report audit findings of the random observations to verify that the facility's is providing valid medical justification for an indwelling catheter and an explanation to the physician of the continued use of the indwelling catheter. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	

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	055764	A. BUILDING _____ B. WING _____	07/21/2012

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F 315	Continued From page 11 limited assistance with eating and needed total assistance with dressing, transfers and personal hygiene. A physician's order since readmission indicated the use of an indwelling catheter for pressure sore management. The Admission Assessment form dated 5/3/12, indicated the presence of scars on the sacrococcyx (tail bone) area. There was no documented assessment the resident had pressure sores upon readmission. An Interdisciplinary Catheter Assessment and Care Plan form dated 5/3/12, documented a Stage IV pressure sore to the sacrococcyx area was healed and there was no further need for the indwelling urinary catheter. By 7/19/12, the resident had no further pressure sores. After the Evaluator inquired about the need of the indwelling catheter, the nurses obtained a physician's order on 7/20/12, to discontinue the indwelling catheter due to the sacrococcyx wound had epithelialized (covered with epithelial tissue). On 7/21/12, at 12:20 p.m., during an interview, Licensed Vocational Nurse 2 (LVN 2) could not explain why the continued use of the indwelling catheter was not relayed to the physician for further orders since the resident's readmission to the facility on 5/3/12.	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 a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services	F 322		

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F 322	Continued From page 12 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 and interview, the facility failed to ensure a syringe plunger did not get contaminated during administration of medications through a gastrostomy tube (GT - tube surgically inserted into the stomach through the abdominal wall for the purposes of nutrition and medication administration) for one randomly selected resident (21). Medication Nurse 1 placed the GT syringe plunger directly onto Resident 21's bedside table, then placed the plunger back in the GT syringe without first cleaning it, and proceeded to administer the resident's medications through the GT the syringe. This had the potential to result in GT contamination and infection. Findings: On 7/20/12, at 5:55 p.m., during the evening medication pass observation for Resident 21, who had a GT for medication administration, Medication Nurse 1 used a 60-cubic centimeter (cc) irrigation syringe. Medication Nurse 1 connected the syringe to the GT, removed the syringe plunger (the part of the syringe that fits inside the tube or barrel of the syringe and once depressed forces fluid out of the syringe) and placed it directly on the bedside table which had not been sanitized and had no protective field. Medication Nurse 1 proceeded to administer	F 322	**[F322] 483.25(g)(2) NG TREATMENT / SERVICES – RESTOITVE EATING SKILLS** **Corrective Action for Affected Residents** The syringe for resident 2 was replaced immediately. The Medication nurse was provided in-service on medication administration through the GT per the facilities policy and procedure. **Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the DON the DSD has been in-serviced license staff on medication administration through the GT per the facilities policy and procedure. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the DON / DSD or designee will monitor for four weeks for three months, and then randomly, the medication nurses during medication administration through the GT to assure the facility's policies, procedures, and practices of medication administration through the GT are followed.	8/11/2012

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F 322	Continued From page 13 several medications through the syringe barrel by gravity, removed the syringe from the GT and then placed the contaminated plunger into the syringe barrel to aspirate into the syringe the remaining medications from a medication cup, and pushed the medications through the GT. Following the medication administration, the medication nurse rinsed the barrel and syringe with water. A review of the clinical record indicated the resident was readmitted to the facility on 6/16/11, with diagnoses that included respiratory failure, congestive heart failure and history of stroke. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/21/12, revealed the resident was severely cognitively impaired and required total care. On 7/20/12, at 7:20 p.m., during an interview, Medication Nurse 1 acknowledged the surface of the bedside table was considered contaminated and he should have placed the barrel on a paper towel or on the sanitized medication tray in order to prevent contamination.	F 322	**Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DON / DSD or designee, will present the evaluations to verify that the medication administration through the GT are followed per the facility's policy and procedures The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary. **[F323] 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION DEVICES** **Corrective Action for Affected Residents** The hot water was adjusted on 7/19/2012 to a temperature below 120 degrees and the identified areas were re-inspected where the results were below 120 degrees. The metal side rails that were identified were padded as ordered by the physician.	8/11/2012
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

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F 323	Continued From page 14 by: Based on observation, interview and record review, the facility failed to ensure the resident environment remains as free from hazards as is possible by having hot water temperatures above 120 degrees Fahrenheit (F) in five hand washing sinks and by not padding the metal side rails of the bed for two of 20 sample residents (1, 16). Resident 1, who had a seizure disorder and had a behavior of banging his upper extremities on the side rails, had unpadded bilateral upper side rails. Resident 16, who was at risk for injuries, did not have padded side rails. This deficient practice had the potential to result in injuries such as burn, scalding, bruising and skin breakdown. Findings: 1. On 7/19/12, between 7:30 p.m. and 8:10 p.m., during the general environmental inspection of the facility, in the presence of the maintenance supervisor, the temperatures of the hot water delivered to plumbing fixtures used in the residents' bathrooms were measured. The unsafe hot water temperatures in the hand washing sinks in the residents' restrooms were as follows: 1. Room 10 - 122.0 degrees F 2. Room 20 - 122.0 degrees F 3. Room 25 - 123.7 degrees F 4. Room 30 - 122.8 degrees F 5. Rooms 14/15 - 122.5 degrees F There were a total of 13 residents residing in the above affected rooms, however, none of the residents sustained any injuries related to the hot water and none of the 13 resident voiced	F 323	**Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the Administrator, The maintenance staff has been in-serviced on maintain an environment free of accident hazards by assuring water temperatures are between 105 - 120 degrees F. The nursing staff has been in-serviced on the application of side rails as ordered. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator, The maintenance staff will monitor for four weeks for three months, and then randomly the facilities water temperatures to assure that they are thermostats and interview residents to determine that the facility is between 105 -120 degrees F. The DON / DSD or designee will monitor for four weeks for three months, and then randomly the application of side rails as ordered. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DON / DSD or designee will report the performed inspections to verify that the facility's in compliance with	

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F 323	Continued From page 15 concerns regarding the water temperature. On 7/19/12, at 8:30 p.m., during an interview, the maintenance supervisor stated he will adjust the high temperatures to 120 degrees F or below. The maintenance supervisor explained he kept a record of daily water temperature and had no prior problem with the water temperature. A review of water temperature log revealed the temperatures taken daily prior to 7/19/12, were below 120 degrees F. The facility's maintenance department policy and procedure on Water Temperature indicated the water temperatures in resident bathrooms and shower room must be between 105 and 120 degrees F. 2. On 7/19/12, at 6:35 p.m., during the initial tour of the facility and on 7/20/12, at 5:45 p.m., Resident 1 was observed lying in a low bed. The four metal side rails of the bed were raised. Only the right lower side rail was padded. A review of the clinical record revealed the resident was admitted to the facility on 12/6/06, and readmitted on 7/26/11, with diagnoses that included seizure disorder and schizophrenia (a mental illness). According to the quarterly Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/3/12, the resident was severely impaired in cognitive skills for daily decision making and required total assistance with activities in daily living (ADLs). An Informed Consent form dated 2/10/12, documented the resident's legal representative consented the use of bilateral upper padded side	F 323	(continue) water temperatures and the use of side rail padding as ordered. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	

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F 323	Continued From page 16 rails to reduce the risk of injury related to resident's episodes of banging the side rails using his upper extremities. A physician's order dated 2/20/12, indicated bilateral padded upper side rails up and locked when the resident was in bed. There was no order to use the bilateral lower side rails. A plan of care developed to reduce the resident's risk of falls and injury indicated to apply bilateral upper padded and locked side rails when the resident was in bed. On 7/20/12, at 9:35 p.m., during an interview, Licensed Vocation Nurse 3 (LVN 3) could not explain the lack of padding on the side rails to prevent the resident from injuring self and could not explain the use of four rails instead of the ordered upper side rails. 3. On 7/19/12, at 6:50 p.m., during the initial tour of the facility and on 7/21/12, at 9:54 a.m. and at 2:05 p.m., Resident 16 was observed lying in bed with four metal side rails up that were not padded. The resident had purplish and greenish skin discolorations on the right forearm and a skin tear on the right hand. There were no devices to protect the resident's upper extremities from hitting the rails. On 7/2/12, at 2:05 p.m., during an interview, the medication nurse stated the resident needed geri-sleeves (geriatric elastic protective arm sleeve) for skin protection and to prevent breakdown and bruising. A record review revealed the resident was admitted to the facility on 3/14/12, with diagnoses that included seizure disorder (convulsions),	F 323		

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F 323	Continued From page 17 osteoporosis (bone tissue that is thin, brittle, and more vulnerable to fracture), legally blind and dementia. The MDS assessment dated 6/21/12, indicated the resident had memory problems and required total assistance with all ADLs. A plan of care dated 6/21/12, developed for the resident's risk for injury secondary to involuntary muscle movements related to seizure disorder, included in the approaches to provide a safe environment, free of safety hazards and to pad the side rails if indicated. Another plan of care dated 7/16/12, developed for the resident's risk for bruising and bleeding related to the use of anticoagulant (blood thinner) medication (Coumadin), fragile skin, diabetes mellitus and aging process, did not include in the approaches the use of skin protective devices (i.e. geri-sleeves, pillows, etc.). A Licensed Nurse Record form dated 7/16/12, timed at 2:45 p.m., indicated the resident was noted scratching, had blood on top of the right hand and an open skin measured two centimeters (cm) in length by 1 cm in width.	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	**[F328] 483.25(k) TREATMENT / CARE FOR SPECIAL NEEDS** **Corrective Action for Affected Residents** Resident 5 IV was discontinued and a new IV was inserted. The date and time of the IV insertion was documented on the dressing. Resident 9 oxygen was restarted 7/19/2012 the O2 saturation was checked with no sign or symptoms of respiratory distress noted. **Corrective Action for Potentially Affected Residents** Other residents with oxygen were checked and all concentrators were on. Other residents with IV's were checked all properly dated and timed. On or before August 11, 2012, under the supervision of the DON, licensed nursing staff has been in-serviced regarding proper IV site labeling and assuring that oxygen concentrators are in use per physician orders.	8/11/2012

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F 328	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident received proper intravenous (IV) and respiratory treatment and care for two of 20 sample residents (5, 9). Resident 5's IV insertion site did not have date and time of insertion, which had the potential to result in possible infection. Resident 9 had a nasal cannula connected to an oxygen concentrator that was turned off and was not receiving oxygen at a rate of two liters per minute (2 L/min) continuously as ordered. This deficient practice had potential to result in shortness of breath. Findings: 1. On 7/19/12, at 6:10 p.m. during the initial tour with the subacute clinical coordinator, Resident 5 was observed lying in bed and was non-verbally responsive. An IV bag with Normal Saline solution was connected to an IV catheter to the resident's right hand and was infusing at a rate of 50 milliliters (ml) per hour. The dressing over the IV catheter insertion site was not dated to indicate when the IV catheter was inserted. During a concurrent interview, the clinical coordinator stated the dressing over the IV insertion site should indicate date and time of the IV insertion, as the site would need to be changed every 72 hours in order to prevent complications including possible infection. A review of the clinical record revealed the resident was admitted to the facility on 6/29/12,	F 328	**Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator the DON / DSD or designee will check for four weeks for three months, and then randomly, IV sites for proper labeling and that oxygen concentrators are in use per physician orders. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then randomly, under the supervision of the Administrator the DON / DSD or designee, will present the reports from reviews, to verify the facility's policy and procedures regarding IV labeling and oxygen concentrators are in use per physician orders. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	

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F 328	Continued From page 19 with diagnoses that included end stage cancer of the throat and neck and acute respiratory failure with tracheostomy. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/19/12, indicated the resident required extensive to total care. According to the facility's policy and procedure on IV Therapy dated 3/2010, the IV site will be labeled with the date and time. 2. On 7/19/12, at 7 p.m., during the initial tour of the facility in the presence of Licensed Nurse 1, Resident 9 was observed lying in bed wearing a nasal cannula (narrow, flexible plastic tubing used to deliver oxygen through the nostrils) connected to an oxygen concentrator that was not delivering oxygen since it was turned off. At the time of the observation, Licensed Nurse 1 proceeded to turn on the oxygen concentrator and stated the resident needed oxygen at a rate of 2 L/min. A review of the clinical record revealed the resident was readmitted to the facility on 5/31/12, with diagnoses that included acute respiratory failure, pneumonia and dementia (progressive loss of memory and other intellectual function). The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/7/12, indicated the resident had memory problems, rarely/never communicated and required total assistance in activities of daily living (ADLs). A physician's order dated 5/31/12, indicated to administer oxygen at 2 L/min via nasal cannula every shift continuously for acute respiratory failure.	F 328		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=D	Continued From page 20 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, distributed and served under sanitary conditions. There were no labels identifying food stored inside the dry food storage room, there was a broken sink faucet, there were missing ceramic tile on the kitchen wall and a fly around the food preparation area. This deficient practice had the potential for cross contamination and foodborne illness. Findings: On 7/19/12, at 6:15 p.m., during the initial tour of the kitchen in the presence of the dietary service supervisor (DSS), the following was observed: 1. Two food trays were stored inside the dry food storage room had not labels. 2. A faucet fixture above the two compartment manual dish washing sink was broken. 3. The wall underneath the dish washing machine had missing ceramic tiles. 4. House flies were noted in the food	F 371	**[F371] 483.35(i) FOOD PROCURES, STORE / PREPARE/SERVE - SANITARY** **Corrective Action for Affected Residents** The identified food trays were discarded. On 7/20/2012 the faucet fixture was repaired and the missing ceramic tile underneath the dishwasher was replaced. The maintenance person checked the pest control devices and found the /in working order on 7/20/2012. No flies were noted in the kitchen on that date. **Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the Dietary Supervisor, kitchen staff has been in-serviced on labeling items; food must be stored and dated with labels identifying the food item. Also the kitchen staff has been in-serviced on reporting needed repairs and pest concerns in the maintenance book. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Dietary Supervisor, the facility will monitor for four weeks for three months, and then randomly, for compliance of proper labeling items to assure that food must be	8/11/2012

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F 371	Continued From page 21 preparation area. According to the facility's policy and procedures on labeling items, food must be stored and dated with labels identifying what it is. At the time of the observation, during an interview, the DSS could not explain the lack of labels on the food items, the faucet and wall disrepair and the presence of flies in the food preparation area.	F 371	continue) stored and dated with labels identifying the food item is. Also monitor the reporting needed repairs and pest concerns in the maintenance book. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for four weeks for three months, and then, under the supervision of the Administrator the Dietary Supervisor will submit a report of findings related to proper labeling of food items and the reporting needed repairs and pest concerns in the maintenance book to verify that the facility's plan of correction is implemented the results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by:	F 425	**[F426] 483.60(a),(b) PHARMACEUTICAL SERVICES ACCURATE PROCEEDUR, RPHP** **Corrective Action for Affected Residents** On or before August 11, 2012, under the supervision of the DON/ DSD or designee has been in-service nurse 1 on the facilities	8/11/2012

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	055764	A. BUILDING _____ B. WING _____	07/21/2012

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F 425	Continued From page 22 Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident for one of 20 sample residents (18) and one randomly selected resident (21). For Residents 18 and 21, Medication Nurse 1 signed the medication administration record (MAR) during preparation and before the administration of the medications, instead of at the completion of the medication administration. This deficient practice had the potential to result in medication errors. Findings: 1. On 7/20/12, at 5:35 p.m., during observation of the evening medication pass for Resident 18, Medication Nurse 1 prepared five medications and two nutritional supplements. After preparing each medication, the medication nurse initialed the MAR and then administered the medications to the resident. A review of the clinical record disclosed the resident was readmitted to the facility on 8/20/11, with diagnoses which included psychosis, seizure disorder and history of stroke. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/12/12, indicated the resident had periods of forgetfulness and required extensive staff assistance with most daily living activities. 2. On 7/20/12, at 5:55 p.m. during observation of Resident 21's medication pass, Medication Nurse 1 prepared five medications and signed the MAR after each medication was prepared. Medication Nurse 1 then administered the medications	F 425	(continue) policy and procedure on medication pass. **Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the Administrator the DON / DSD or designees has in-service the license nurses on the facilities policy on medication pass procedure. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator the DON / DSD or designee will randomly perform a medication pass assessment for four weeks for three months on medication nurses. **Measures Adopted for Systemic Change and Quality Assurance** These observations will take place for weeks for three months, and then randomly, under the supervision of the Administrator the DON / DSD or designee, will present the reports from reviews, to verify the facility's policy and procedure on medication pass procedure. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and	

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F 425	Continued From page 23 through the resident's gastrostomy tube (GT- a tube which is surgically inserted into the stomach for purposes of nutritional support and medication administration). A review of the clinical record revealed the resident was readmitted to the facility on 5/16/11, with diagnoses that included respiratory failure, congestive heart failure and history of stroke. The MDS assessment dated 5/21/12, revealed the resident was severely cognitively impaired and was totally dependent on staff for all of his daily living needs. The facility's policy and procedure titled "Procedures for All Medications" dated 4/2008, stipulated to document medication administration on the MAR following medication administration. On 7/20/12, at 7:20 p.m. during an interview, Medication Nurse 1 acknowledged the MAR should be initialed/signed off following administration of the medications.	F 425	(continue) evaluation of any further corrective action as necessary.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**[F428] 483.60(c) DRUG RIGIMEN REVIEW, REPORT IRREGULAR, ACTION** **Corrective Action for Affected Residents** The medication order was clarified with the attending physician. A new order was given to address the resident's pain levels. **Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the DON the Pharmacist has been in-serviced on the importance of identifying and reporting drug irregularities and reporting them to the physician and DON.	8/11/2012

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F 428	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the pharmacist failed to identify and report drug irregularities for one of 20 sample residents (3). Resident 3 had an order for Tylenol and Vicodin for moderate pain, the pain scale required to give the Vicodin was not indicated, and the pharmacist did not identify the drug irregularities. This failure had the potential to result in medication error and adverse consequences. Findings: On 7/19/12, at 6:45 p.m., during the initial tour, Resident 3 was observed lying in bed and stated he had cancer, lost his hair due to chemotherapy treatment and had frequent headaches and body aches. A review of the clinical record revealed Resident 3 was admitted to the facility on 6/15/12 with diagnoses that included brain mass (tumor), kidney cancer, status post chemotherapy treatment and was currently receiving radiation therapy. The admission Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/21/12, indicated the resident was able to make his needs known, was able to understand others and required supervision to extensive assistance in activities of daily living (ADLs). The physician's orders on admission included acetaminophen 325 milligrams (mg) two tablets orally every four hours as needed (PRN) for mild pain (1-3 on a pain rating scale from zero to 10, zero indicating no pain and 10 the worst possible pain), acetaminophen 500 mg two tablets orally	F 428	**Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the DON, The Pharmacist reports will be evaluated monthly and discussed in Exit with the DON and Administrator to address needed interventions. **Measures Adopted for Systemic Change and Quality Assurance** On a quarterly basis for six months, under the supervision of the Administrator the DON or designee, will present the reports from reviews, to verify the staff is complying with Pharmacist reports. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	

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F 428	Continued From page 25 every four hours PRN moderate pain (4-6/10) and an order for one tablet of Vicodin 5/500 mg by mouth every four hours PRN for moderate. There were two pain medications for moderate pain but there was no pain medication ordered for severe pain. According to a Pain Assessment Flowsheet, the resident received Vicodin for general body pain and headache for a pain rated 8/10 (severe pain) on 7/10/12, 7/11/12, 7/15/12, 7/16/12 and 7/19/12. A recapitulation physician's orders for the month of 7/2012, were stamped, signed and dated on 7/18/12, by the pharmacist indicating the orders were reviewed by the pharmacist. On 7/20/12, at 6:40 p.m., after reviewing the physician's order and the medication administration record (MAR), Licensed Vocational Nurse 3 (LVN 3) stated the physician would be contacted to clarify the resident's pain medications. On 7/20/12, at 6:45 p.m., during an interview, the director of nursing stated the pharmacist performs medication review for each resident once a month and there was no report of any irregularity related to the resident's pain medications. The director of nursing further indicated Vicodin should be given for severe pain.	F 428		
F 458 SS=B	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.	F 458	**[F458] 483.70(d)(1)(ii) BEDROOM MEASURES AT LEAST 80 SQ FT / RESIDENT** **Corrective Action for Affected Residents** On 7/21/2012 the facility submitted a variance request for accommodation.	8/11/2012

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F 458	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all bedrooms measured at least 80 square feet per resident in multiple resident bedrooms. Findings: A total of 11 multiple resident rooms did not measure 80 square feet per resident. Rooms 14, 15 and 18 accommodated two residents, Rooms 5, 6, 8, 9, 11, and 12 accommodated three residents and Rooms 16 and 17 accommodated four residents. According to the facility's submitted variance request and the Analysis of Client Accommodation dated 7/21/12, the following rooms were below the 80 square feet: Rooms — Number of Beds — Square feet 5 — 3 — 204.24 6 — 3 — 202.02 8 — 3 — 220.32 9 — 3 — 220.32 11 — 3 — 222.84 12 — 3 — 220.32 14 — 2 — 155.04 15 — 2 — 156.06 16 — 4 — 286.80 17 — 4 — 286.80 18 — 2 — 153.00 During the survey period from 7/19/12 to 7/21/12, observation of the above listed rooms revealed the space available for the residents was sufficient to provide access and freedom of	F 458	**Corrective Action for Potentially Affected Residents** Staff will assure that the listed rooms maintain the space available for the resident has sufficient to provide access and freedom of movement. **Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Maintenance staff or designee, will monitor randomly, for compliance of the listed rooms are maintained so the space available for the resident's is sufficient to provide access and freedom of movement. **Measures Adopted for Systemic Change and Quality Assurance** On a quarterly under the supervision of the Administrator the Maintenance staff or designee, will present the reports from reviews, to verify that monitoring to assure that the listed rooms are maintained so that the space available for the resident's is sufficient to provide access and freedom of movement. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	

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F 458	Continued From page 27 movement.	F 458	**[F469] 483.70(h)(4) MAINTAIN EFFECTIVE PEST CONTROL PROGRAM**	8/11/2012
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to maintain an effective pest control program and be free of pests. Three of 11 resident attending the group meeting complained of having flies in their rooms and one randomly selected resident (22) was observed with a fly on the bed covers. Findings: 1. On 7/19/12, at 6:10 p.m., during the initial tour of the Subacute Unit with the subacute clinical coordinator, a fly was observed crawling on Resident 22's bed covers. The resident was unable to participate in an interview, had physical limitations and could not remove the fly from his bed. During a concurrent interview, the clinical coordinator stated flies should not be in residents' rooms and proceeded to remove the fly from the resident's bed. A review of the clinical record revealed the resident was readmitted to the facility on 3/13/12, with diagnoses which included respiratory failure with tracheostomy (tube surgically inserted into	F 469	**Corrective Action for Affected Residents** On or before August 11, 2012, under the supervision of the Administrator the pest control person has inspected and evaluated the facility for sources and or cause of the noted flies. There was no source of flies noted from the facility. **Corrective Action for Potentially Affected Residents** On or before August 11, 2012, under the supervision of the Administrator, the Maintenance and Environmental Services and other staff has been in-serviced regarding maintaining an effective pest control program to be free of pest. The contracted pest control person was instructed to include in her reports any issues regarding pest including flies.	

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F 469	Continued From page 28 the trachea, or windpipe, for purposes of airway access and removal of secretions), ventilator (breathing machine) dependent and gastrostomy tube (GT). The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/23/12, indicated the resident was severely cognitively impaired (rarely/never makes decisions), was incontinent of bowel and bladder and was completely dependent on staff for all activities of daily living (ADLs). On 7/21/12, at 11 a.m., an observation of one of the exit doors close to the resident' room revealed no insect trap device to prevent flies from entering the facility. 2. On 7/21/12, at 10 a.m., during the Quality of Life Group interview with 11 alert and oriented residents in attendance, three residents complained about having flies in their room. The resident stated having flies in their room made them upset. A review of the Pest Management Reports dated 5/18/12, 6/20/12 and 6/29/12, revealed the reports by the contracted pest control company did not address the fly infestation.	F 469	**Monitoring of Corrective Action** On or before August 11, 2012, under the supervision of the Administrator, the facility will monitor the environment to assure that the facilities pest prevention interventions are in place, functioning and maintaining an effective pest control program according to the facility's policies and procedures and quality assurance program. **Measures Adopted for Systemic Change and Quality Assurance** On a quarterly basis, under the supervision of the Administrator the Maintenance Director or designee will present a report of the inspections to verify that the facility's policy and procedures regarding the pest control program is implemented and effective. The results of such evaluations shall be documented on Quality Assurance forms. The results of such audits shall be submitted to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary.	