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

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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
	555639	A. BUILDING ___ B. WING ___	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF NAPA VALLEY	1900 ATRIUM PARKWAY NAPA, CA 94559

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the ANNUAL RECERTIFICATION SURVEY from 6/24/19 to 7/2/19. Representing the California Department of Public Health: Health Facilities Evaluator Nurses # 40254, #37797, #40090, #41333, #41757. The census on the day of entry was 43. There were 16 sampled residents. Facility-Reported Incident #CA00631067, was investigated during the RECERTIFICATION SURVEY. There were no deficiencies.	F 000	**F 000** This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42C.F.R. 405.1907. _________. Initials **Form CMS-2567 was received on August 16, 2019. The amended CMS-2567 was received September 3, 2019.**	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	**F 550** • Resident 20 will be treated with dignity and respect by involving her with her care and respecting her preferences. A care conference was done for resident 20 on 7/25/2019. During this care conference the Social Services Designee (SSD) and Director of Nursing (DON) reviewed her preferences and adjusted the shower schedule for resident 20 per resident choice. The IDT team provided education about the	8/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	EXECUTIVE DIRECTOR	9-6-2019

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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POC accepted on 9/6/19 @ 4:45 pm facility notified 9/6/19. [illegible] evidence of compliance [illegible]

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on Observation, interview, and record review, the facility failed to ensure one of 16 sampled residents (Resident 20) was treated with dignity and respect, by maintaining and enhancing her self- esteem and self-worth, by involving her preferences and choices of Activities of Daily Living (ADL's), such as showers. The facility failed to consider Resident 20's life style and personal choices disregarding her needs and preferences. Staff failed to implement the established shower scheduled for Resident 20.	F 550	importance of respecting patient preferences and documenting wishes. • It is the policy of the facility to assure residents the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility does protect and promote the rights of all residents, regardless of their diagnosis, severity of condition, or payment source, through educating employees about resident rights during in-services trainings as well as through educating residents of their Federal Resident Rights and State Residents Rights upon admission and during monthly Resident Council meetings. CNAs in-serviced on documentation of shower refusals on 8/27/2019. Shower assignments are noted on the employee sign-in sheet since 7/1/2019, for each shift. CNAs were in-serviced on documentation of shower refusals on 8/27/2019. Shower assignments are noted on the employee sign-in sheet since 7/1/2019, for each shift.	

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F 550	Continued From page 2 Staff failed to treat resident 20, equally, when compared to other residents who received showers twice or more in a week. These failures negatively impacted Resident 20's psychosocial well-being, quality of life and quality of care. Findings: During an interview on 6/25/19 at 1:57 p.m., Resident 20 stated, "I would like to have more showers than once a week. I showered once a week since last year." Resident 20 stated, "I have requested to a Certified Nursing Assistant (CNA, not identified by resident) to get more showers," the CNA said they did not have extra staff. "So, I don't ask anymore for extra shower, I just wait for them to come and get me. In my home, I showered every day so I don't feel dirty. When I feel dirty, I'd rather stay in my room." This feeling of dirty resulted in Resident 20 to feel ashamed and embarrassed. In record review of shower schedules, all residents were scheduled to have two showers in a week. Resident 20 had one shower each week and one weekend in June. Resident 20 stated, "I will be upset if other residents get showers more than once a week." In review of Resident (51) and Resident (48)'s shower schedules, they had two showers each week, as scheduled. Resident (23) had three showers in one week. Resident 20 was not informed she was scheduled for two showers in a week, and staff did not perform her showers as scheduled. In comparison, Resident 20 did not have an equal amount of showers weekly. During a record review and concurrent interview	F 550	• The systemic changes that will be put into place to ensure all residents feel treated with dignity and respect and are involved in choices of activities of daily living include the SSD documenting reassessment of resident preferences during scheduled Care Conferences. All residents have Care Conferences and are made aware of their rights for showers during this time as well as at admission. In addition, CNAs will be inserviced/educated about preferences and documenting refusals upon hire and annually. • The facility plans to monitor this with the Nursing Management team (DON, Assistant Director of Nursing (ADON), and/or designated Nursing Manager/s). Audit results will be done by the Resident Care Managers (RCMs) for resident choice of showers and shower assignments, and corrective actions will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audits and reports will be determined by the QAPI committee in January 2020.	

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F 550	Continued From page 3 on 6/27/19 at 1:45 p.m., CNA (L) stated, "I wrote on a shower sheet for each resident who received showers on that day. If a resident refused to shower, I would write, "refused," then submitted to the RN." In the shower binder, Resident 20 had four shower sheets for May 2019, and five shower sheets for June 2019. CNA (L) did not find any shower sheets for Resident 20 which indicated showers were not done due to family outing or refusal. During an interview on 6/27/19 at 2:30 p.m., the Interim Director Of Nursing (DON) stated, when a resident refused a shower, the CNA wrote down, "refused," on the sheet. The Interim DON stated, the reason resident 20 did not get the shower was because she would ask to get it during the change of shift (staff reports to incoming staff) at 2:30 p.m. The Interim DON did not find any refusal sheet for resident 20. The Interim DON confirmed Resident 20 received a total of four showers in the month of May; a total of five showers (four during weekdays and one on the weekend) in the month of June. Staff did not ask Resident 20 for, and did not negotiate, her preferences for showers. This failure resulted in Resident 20 being unable to exercise her rights to voice her personal choices to obtain her needs for more showers.	F 550		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or	F 585	**F 585** • The requirement for resident to voice grievances is and will be honored at the facility, and affected 8 of 8 residents. Resident 16 had a grievance that was addressed by the SSD on 7/2/2019; the SSD offered to file a grievance on behalf of the resident; the resident declined filing a grievance because the issue was already taken care of.	8/31/19

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F 585	Continued From page 4 reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey	F 585	• It is the policy of the facility that each resident has a right to voice grievances/concerns without discrimination or reprisal. The SSD attended the Resident Council meeting on 8/15/2019 to explain the grievance policy/complaint form. • The systemic changes that will be put in place to ensure all residents are aware of the policy regarding grievances include requiring the SSD to provide a copy of the grievance policy to the resident during the admission process as an attachment to the admission agreement. The admission agreement will include the grievance policy starting 8/23/2019. Additionally, bi-monthly reviews of the grievance policy will be offered at the Resident Council meetings starting 8/15/2019. Medical Records (MR) will be auditing the admission packets to ensure a copy of the grievance policy is provided at admission. For residents not in attendance at resident council meetings, the grievance policy has be posted at the nursing station and in the activities room for review.	

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F 585	Continued From page 5 Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as	F 585	• The facility plans to monitor the grievance POC with the Administrator, SSD, and MR. Minutes from the Resident Council meeting will reflect bi-monthly SSD grievance reviews and will be reviewed by the Administrator to ensure POC is achieved and sustained. The continued frequency of these audits will be determined by the QAPI committee in January 2020.	

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F 585	Continued From page 6 the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, eight of eight residents stated they did not know how to file a grievance. This failure had the potential to cause residents to feel their needs were not being met. Findings: During group meeting on 6/25/19 at 10:30 a.m., eigt of eight Residents stated they did not know how to file a grievance. Resident 16 stated, to a certain extent, she had a grievance against an aid, she made a complaint to the office staff, they wrote her issue on a piece of paper, had her sign it, but nothing else done. Resident 16 stated she did not have a lot of confidence in complaining and having something done about it. During interview and concurrent record review, with Admissions staff (Admissions keeps logs of grievances filed) on 6/28/19 at 10 a.m., the Grievance Log Book was reviewed. Admissions/SS staff indicated she had no record of Resident 16's complaint, but would check with Resident 16.	F 585		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	F 657 • Resident 25's care plan for falls was updated on 7/10/2019. This resident has had no falls to date following this care plan revision and revised interventions. Resident 42's care plan for UTIs was updated on 8/6/2019. This resident has had no UTIs to date following this care plan revision and revised interventions.	8/31/19

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F 657	Continued From page 7 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely revise and update the comprehensive care plans of two of 16 sampled residents (Residents 25 and 42) when: 1) Resident 25 had an accidental fall on 6/1/19, and her comprehensive fall care plan was not revised and updated to include additional fall prevention interventions. This failure placed Resident 25 at risk of additional falls.	F 657	• It is the procedure of the facility to conduct a resident assessment in a timely manner upon resident's admission to the facility. Based on the resident's admission assessment completed by the interdisciplinary team (IDT), an admission baseline care plan is to be developed within 48 hours of admission. Within 21 days of admission and/or within 7 days after the completion of the comprehensive assessment, the IDT, including the resident and/or responsible party will develop a comprehensive care plan. It is the policy of the facility that care plans be reviewed and revised by the IDT after each assessment, including comprehensive, quarterly, condition change and significant change assessments. All resident care plans were further reviewed by DON and Resident Care Managers (RCMs) by 8/31/2019 to ensure completeness and that needed interventions are in place. • The systemic changes include the RCMs ensuring care plans are created, and revised per the above schedule in collaboration with the IDT. Care plan updates will be discussed at daily stand-up meetings. Medical records will	

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F 657	Continued From page 8 2) Resident 42 acquired a Urinary Tract Infection (UTI) on 6/18/19, and her comprehensive care plan was not revised and updated to include UTI interventions, until 6/26/19. This failure placed Resident 42 at risk of not receiving timely nursing interventions for her UTI. Findings: 1) A review of Resident 25's face sheet indicated she was 78 years-old and was admitted to the facility on 4/24/19, with diagnoses which included heart failure, edema, hypertension, chronic kidney disease stage five, atrial fibrillation, muscle weakness and unsteadiness on her feet. A review of Resident 25's Incident Reports indicated Resident 25 had a fall at the facility on 6/1/19. An Incident Report dated 6/20/19 at 5:04 p.m., indicated Resident 25 was found on the floor next to her bed on 6/1/19 at 4:45 a.m. The Incident Report indicated contributing factors to the fall were, "generalized weakness, impaired coordination, meds (medications), impaired cognition, poor safety awareness." A review of Resident 25's comprehensive care plans indicated a fall prevention care plan dated 4/25/19. The goal of the care plan was, "Resident will have zero falls or injuries." The fall care plan contained no mention of the 6/1/19, fall and had no update, or revision, as a result of the fall on 6/1/19. During an interview on 7/2/19, starting at 9:50 a.m., the Director of Nursing (DON) reviewed Resident 25's record, and stated Resident 25's fall care plan should have been revised and	F 657	audit for careplan completion and revision with scheduled assessments and changes in condition. Staff will be provided training on care planning and changes in condition annually. • The facility plans for the DON to monitor for compliance and completion of careplans/audits. During monthly QAPI Committee meetings trends will be reported to ensure POC is achieved and sustained through January 2020. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	

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F 657	Continued From page 9 updated after the fall on 6/1/19. Facility policy titled, "Care Planning," dated 1/2018, indicated: "Care plans will be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive, quarterly, condition change and significant change assessments." 2) A review of Resident 42's admission record indicated she was admitted to the facility on 5/29/19, with diagnoses which included urinary retention. A review of Resident 42's admission Progress Note dated 5/29/19 at 9:39 p.m., indicated Resident 42 had a indwelling Foley catheter (a tube to drain urine from the bladder). A review of Resident 42's comprehensive care plan indicated a care plan titled, "Urinary Incontinence," dated 5/30/19, with a goal that, "Resident [42] will be fee of UTI [urinary tract infections] symptoms and complications." A review of Resident 42's Progress Note dated 6/18/19 at 11:26 a.m., indicated Resident 42 was experiencing pain with urination, and Resident 42's urine had tested positive for infection (A symptom of UTI is pain during urination). (https://medlineplus.gov/urinarytractinfections.html) A review of Resident 42's comprehensive care plans indicated they were revised and updated with additional interventions to treat Resident 42's UTI on 6/26/19, eight days after Resident 42 was diagnosed with the UTI.	F 657		

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F 657	Continued From page 10 During an interview on 7/2/19, at 10:33 a.m., the Director of Nursing (DON) reviewed Resident 42's record and indicated the comprehensive care plan should have been revised to include UTI interventions when the UTI was detected on 6/18/19, and not eight days later on 6/26/19. Facility policy titled, "Care Planning," dated 1/2018, indicated: "Care plans will be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive, quarterly, condition change and significant change assessments."	F 657		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676	F 676 • The facility will ensure and provide the necessary care and services to maintain residents' level of mobility. Resident 3, 16 and 49 remain on the Restorative Nursing Program caseload. All residents have been participating in their respective programs as scheduled. There has been no evidence nor report of increased depression, functional decline, or reduced likelihood of discharge among these residents. Resident 27 was discharged to the hospital on 8/2/2019.	8/31/19

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F 676	Continued From page 11 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to maintain residents' level of mobility for four of 19 sampled residents (Resident 3, Resident 16, Resident 27, and Resident 49). Which had the potential to result in: Functional decline, reduced likelihood of discharge, and increased risk for depression. Findings: During an interview with Resident 16, on 6/24/19, at 10:54 a.m., she stated she wanted to go home. Resident 16 stated the facility staff did not know what to do for her. When asked if she was getting services to get stronger to assist with her ability to go home, Resident 16 said, "yes," but it was not happening. During an interview with Resident 3's family member, on 6/24/19, at 2:30 p.m., he stated	F 676	• It is the policy of the facility to develop and implement a nursing rehabilitation/restorative care program to help residents achieve and/or maintain optimal physical, mental, and psychosocial functioning. Restorative Nursing Programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when he/she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when a restorative need arises during the course of a custodial stay. • Restorative Nurse's Aides (RNAs) will not be reassigned to CNA duties going forward, rather other means of finding staff will be implemented to cover CNA assignments. This includes utilizing a recruiter to further obtain qualified staffing and partnering with local programs to train a future workforce. The HCA and DON will ensure RNA staff are not reassigned to cover CNA duties. HCA and DON will collaboarate with HR to ensure adequate RNA and CNA staff are in place. The DSD shall ensure all	

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F 676	Continued From page 12 Resident 3 was getting therapy help, but it was stopped due to insurance. The family member expressed concern about the lack of services after therapy was completed. He said Resident 3 did well with therapy, but all the progress was lost after that. The family member was visibly frustrated; he said it was a cycle of weakness which allowed Resident 3 to qualify for therapy services. Once Resident 3 was discharged from therapy, no one worked with her, so she would revert back. During a review of Resident 3's clinical record, the Restorative Assessment / Referral, dated 5/14/19, was signed by therapy, but the Nurse signature was blank. There was no documentation the Restorative Nursing Assistants (RNA's) had worked with Resident 3 prior to the survey team's entrance. During a review of Resident 27's clinical record, the Restorative Assessment / Referral, dated 5/28/19, was signed by therapy, but the Nurse signature was blank. There was no other documentation the assessment was carried out. During an interview with the Interim Director of Nursing (DON), on 6/26/19, at 3:44 p.m., he stated no one was officially running the RNA program, but the Director of Nursing was covering. The Interim DON stated charting was completed on paper by two Restorative Nursing Assistants (RNA's). Documentation on all residents with orders and the RNA documentation, for the last 30 days, was requested. During a review of Resident 49's clinical record, the Orders section indicated orders for	F 676	RNA staff are trained upon hire and annually related to correct documentation and compliance with RNA program. RCMs will manage RNA program to ensure programs are being initiated upon discontinuation of therapy and updated as needed. RCMs will ensure RNA program is being carried out by RNAs and monitor program and documentation for compliance. RCMs will collaborate with IDT for any issues or needed revisions to the RNA plan. • The facility plans to monitor this POC with the RCMs completing weekly audits of RNA notes and through Restorative Nursing Program meetings held weekly as of 8/27/2019. Audit results and corrective actions will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	

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F 676	Continued From page 13 Restorative Nursing activities. A review of the Restorative Nurse Assistant section indicated no flow sheet for Resident 49. During an interview with the Interim DON, and concurrent record review, on 6/27/19, at 10 a.m., he confirmed Resident 49 was not getting RNA service. During a review of Resident 16's clinical record, the Restorative Nursing Care Flow Record had five different tasks on one flow sheet. The Weekly Narrative Notes were blank. There was no way to know what was done, or not done, for Resident 16. During a review of the daily staff binder, the daily shift sign-in log for June indicated RNA's were assigned to work as Certified Nursing Assistants on June 8th and 9th. During an interview with Restorative Nursing Aide L (RNA L), on 6/27/19, at 8:44 a.m., a description of daily responsibilities was discussed. RNA L stated sometimes it was pretty busy. They helped residents transfer out of bed and into their chair. RNA staff took daily weights, weekly weights and monthly weights. RNA L stated they assist with both meals, which took approximately 2.5 hours of time. RNA staff were expected to escort residents to and from appointments. RNA L confirmed there were days exercises did not get done. RNA L stated they did not have time. When the facility was short staffed, they would reassign RNA's to the floor to do Certified Nursing Assistant (CNA) work. RNA L stated it was happening more often now. The practice of removing RNA staff from that duty, to cover CNA work, started about a year ago. With 24	F 676		

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F 676	Continued From page 14 residents on RNA duty, seven to ten residents had orders for ambulation and ROM (Range of Motion) exercise. RNA L confirmed they could not get their work done. During an interview with the Interim Director of Nursing (DON), on 6/27/19, at 9:39 a.m., he confirmed the RNA program was not fully functional. The Interim DON stated there were no consistent RNA meetings. Treatments were not being done consistently. The Restorative Nursing Care Flow Records were not being filled in completely or accurately. The Interim Don confirmed the facility had two RNA staff, and four days a week, only one was working. When asked when was the last time, in addition to their other duties, the RNA staff were getting all the work done, he agreed, they could not. During a review of the Restorative Assessment / Referrals, dated 5/19, seven documents were incomplete. The portion to be completed by the nurse, with instruction on which staff would implement the plan, was blank. The implementation dates for all seven referrals were blank. The facility policy and procedure titled, "Restorative Program: Nursing Rehabilitation/Restorative Care," last revised 8/13, indicated the goal of the program was to help residents achieve and maintain optimal physical, mental, and psychosocial functioning. The procedure indicated the Administrative Nurse would initiate the Restorative Aide Documentation sheets that list the exact order for the Restorative Nurse Aides to follow. The policy further indicated the orders would be carried out on a daily basis.	F 676		

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F 684 F 684 SS=D	Continued From page 15 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 16 sampled residents (Resident 25) received treatment and care, in accordance with professional standards of practice, when the facility administered Carvedilol (a blood pressure medication) to Resident 25, without food, on an empty stomach. The Food and Drug Administration (FDA) recommends administering Carvedilol with food to slow the rate of absorption and prevent sudden loss of blood pressure, which can result in dizziness, loss of consciousness and falls. Approximately 30 minutes after being given Carvedilol on an empty stomach, Resident 25 fainted and fell, injuring her knee and face. Findings: A review of Resident 25's face sheet indicated she was 78 years-old and was admitted to the facility on 4/24/19, with diagnoses which included heart failure, edema, hypertension, chronic kidney disease stage five, atrial fibrillation, muscle weakness and unsteadiness on her feet.	F 684 F 684	F 684 • The facility will ensure all residents will receive treatment and care in accordance with professional standards of nursing practice, resident care plan and choices. Resident 25's medication regimen has been updated and is no longer taking Carvedilol. • It is the policy of the facility to maximize resident independence and choice through resident-centered medication administration to support their choice in awake times, sleep times, meal times, uninterrupted family visits, and therapy participation. It is the procedure of the facility to consider the resident (i.e. right to self-administer) and program implementation (i.e. timeframes) during medication administration. The reference "Medications and their Relationship to Foods" is available as a resource to nursing staff as well as noted in the policy as a reference tool. An in-service to nursing staff was completed 8/26/2019 outlining the information noted in the tool. • The systemic changes that will be put into place to ensure that residents receive treatments in	8/31/19

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F 684	Continued From page 16 During an observation on 6/25/19, at 4:29 p.m., Resident 25 had bruises on her face. During a concurrent interview, when asked what caused the bruises, Resident 25 stated she fell a few weeks ago at the facility. Resident 25 explained she felt, "dizzy, blacked-out and fell." Resident 25 stated when she fell, she hurt her knee and chin. A review of Resident 25's Progress Note dated 6/12/19 at 3:32 p.m., indicated Resident 25 fell on 6/12/19, and injured her face, as follows: "At approx 0910 (9:10 a.m.), resident sustained witnessed fall. Resident was walking to her bed by herself, lost balance, landed on her hand and knees and hit her upper lip on the side of the bed... Resident noted with 2 skin tears to L (left) arm... and... to upper lip..." A review of Resident 25's Incident Reports indicated Resident 25 had a previous fall at the facility on 6/1/19. An Incident Report dated 6/20/19 at 5:04 p.m., indicated Resident 25 was found on the floor next to her bed on 6/1/19 at 4:45 a.m. The Incident Report indicated that contributing factors to the fall were, "generalized weakness, impaired coordination, meds (medications), impaired cognition, poor safety awareness," and pertinent medications were, "Cipro [an antibiotic], Carvedilol [for blood pressure], Bumetanide [for edema/swelling], Coumadin [a blood thinner] and Meltonin [sleep medication]." A review of Resident 25's Medication Administration Record (MAR) indicated a order for Carvedilol 6.25. mg (milligrams) 1 tablet twice a day (8 a.m. and 6 p.m.), for hypertension (high blood pressure). The order did not indicate to take it with food.	F 684	accordance with professional standards of practice include the DON providing in-service education to all Licensed Nurses (LNs) regarding the reference "Medications and their Relationship to Foods", as well as quarterly audits by the Pharmacy Nurse Consultant to ensure LNs follow professional standards of nursing practice, including providing medications with food as prescribed. ▪ The facility plans to monitor this POC with the DON and MR auditing the medication administration record (MAR) and LN/CNA documentation. Audit results and corrective actions from the Pharmacy Nurse Consultant, DON, and MR will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	

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F 684	Continued From page 17 A review of the facility's drug reference book, "Nursing 2016 Drug Handbook" (Drug Handbook), indicated Carvedilol's adverse reactions included, "dizziness... vertigo... and syncope (fainting)." Under, "Patient Teaching," the Drug Handbook indicated, "Inform patient that he may experience low BP [blood pressure] when standing...," and to take Carvedilol, "with food." During an interview on 7/2/19, at 10:41 a.m., the Director of Nursing (DON) reviewed Resident 25's MAR for June 2019. The DON confirmed Resident 25 received the morning Carvedilol dose on 6/12/19, and Resident 25's blood pressure, prior to the administration, of Carvedilol was 103/70 (systolic/diastolic; normal is 120/80). The DON confirmed Resident 42's order for Carvedilol did not indicate to take it with food. The DON stated taking Carvedilol without food could cause the blood pressure to, "tank" (drop precipitously). A review of the facility's meal times indicated breakfast service ended at 8:30 a.m. During a record review on 7/2/19, at 10:41 a.m., the DON provided a copy of Resident 25's meal consumption records, which indicated Resident 25 consumed 10% of her breakfast on 6/12/19. During an interview on 7/2/19, at 10:41 a.m., the DON stated Carvedilol was administered to Resident 25 on 6/12/19 at 8:39 a.m. A Progress Note dated 6/12/19 at 3:32 p.m., indicated Resident 25 fell on 6/12/19 at 9:10 a.m., 31 minutes after the administration of Carvedilol. A review of facility Incident Report for the fall on 6/12/19, titled Investigation/Follow-up dated	F 684		

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F 684	Continued From page 18 6/20/19, indicated for the facility's consultant pharmacist to conduct a drug regimen review for Resident 25. A review of Resident 25's drug regimen review indicated a, "Clinical Review," of Resident 25's medications dated 6/21/19, for the reason of, "Actual falls." In the Clinical Review, the consultant pharmacist made the following comment and recommendation, with regards to Resident 25's medications: "Carvedilol can commonly cause dizziness... May consider administering this medication with food as recommended." The Food and Drug Administration (FDA,) "Highlights of Prescribing Information," for Carvedilol, indicated, under Dosage and Administration that, "[Carvedilol] should be taken with food to slow the rate of absorption and reduce the incidence of orthostatic effects." (https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020297s038lbl.pdf). According to the American Academy of Physical Medicine and Rehabilitation, orthostasis is a decrease in blood pressure after standing that, "often causes lightheadedness, dizziness and fainting, which in turn leads to falls and injuries." (https://www.aapmr.org/about-physiatry/conditions-treatments/medical-rehabilitation/orthostasis.)	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686	**F 686** • The facility will ensure and provide preventive measures and treatments consistent with professional standards of practice for all resident wounds. Resident 1's skin care plan was updated on 7/9/2019. A softer brace was used in addition to further pillow cushioning. This resident has had no further skin injuries to date following this care plan revision and revised interventions.	8/31/19

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F 686	Continued From page 19 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility filed to provide preventative measures, consistent with professional standards of practice, to one of 16 residents (Resident 1). The facility failed to provide treatment consistent with professional standards of practice to an existing surgical wound to the right hip and right knee. The facility failed to ensure Resident 1 did not develop avoidable skin injuries, failed to identify Resident 1 was at risk for skin injuries and failed to provide interventions to prevent further skin injuries. These failures resulted in Resident 1 acquiring five skin injuries to his left leg, nine days after admission. Findings: During an observation and concurrent interview on 6/29/19 at 10 a.m., Resident 1 was lying down in his bed with his right knee immobilizer (a long divide to keep knees straight and prevent knees from moving freely, with Velcro attachments) in	F 686	• It is the policy of the facility that LNs complete for all residents, a skin risk assessment to identify those at risk so that interventions can be put in pace to minimize risk of skin injury/impairment. It is to be done upon admission, quarterly, and with change in condition. It is the policy of the facility that residents be monitored at least daily or more often if acute condition exists. Preventive skin care will be done on an ongoing basis per each patient's plan of care. Prompt attention will be given to residents with identified skin impairment to avoid pressure injuries or other skin issues. RCMs and LNs were in-serviced on 7/23/2019 and again on 8/26/2019 in how to complete a skin care plan. In addition to maintaining up-to-date skin care plans with effective interventions; the DON in-served the nursing staff in how to properly change and date bandages with date, time and initials on 8/26/2019. The DON, since 7/3/2019, has been auditing skin care plans within 72 hours of admission. • The systemic change the facility will put into place includes the DSD ensuring that staff have	

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F 686	Continued From page 20 place to his right knee, and his right leg was raised on pillows. The left leg was bare, and skin injuries were covered with a total of five dry bandages. Resident 1 stated he got the sores from rubbing against the immobilizer. During record review and concurrent interview on 6/26/19 at 2 p.m., Physical Therapist A (PT A) stated she noticed the skin injuries on 6/15/19 and reported to an RN (Registered Nurse). PT A stated the plans were t to order a new knee immobilizer to prevent further skin injury. PT A stated Resident 1 was to wear sweat pants when up in a wheelchair to prevent the knee immobilizer from rubbing against the other leg. On 6/15/19, Physical Therapy notes indicated, "Resident has 2 superficial abrasions on left inner knee and left inner ankle potentially caused by the brace on right leg." A review of Resident 1's plan of care, "Skin At Risk, page 13, dated 6/14/19, there were no written instructions to prevent further skin injury. During an observation and concurrent interview on 6/26/19 at 1:15 p.m., Licensed Nurse C (LN C) stated the old bandages (dressings) had dates noted as 6/25/19, to the left lower leg. LN C verified the bandages on the right hip and right knee, had dates noted as 6/22/19. The bandages on the right knee and right hip were not changed since 6/22/19. In the electronic Treatment Administration Record (eTAR), RNs signed on 6/23/19, 6/24/19 and 6/25/19, indicating the bandages were changed on those dates. During an interview on 6/26/19 at 2 p.m., the Interim Director of Nurses (DON) indicated RNs signed the eTAR after they had changed the	F 686	training on how to document on skin care plans for residents. The RCMs will ensure all care plans are in place and updated for changes in condition and per assessment schedule. The MR coordinator will further audit care plans to ensure they are complete and in place following admission or changes in condition. The DON will perform 72 hour audit for accuracy, and completion. • The facility plans to monitor this POC with the DON and MR. The DON will continue to monitor for compliance. Audit results and corrective actions will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	

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F 686	Continued From page 21 bandages. During an interview on 6/26/19 at 3 p.m. and 6/28/19 at 10 a.m., LN D (who signed the eTAR on 6/24/19) stated she signed the eTAR first, then Resident 1 was taken for physical therapy, "I forgot to change the dressing." LN E (who signed the eTAR on 6/25/19) stated, "I signed the eTAR for the right leg and changed the bandages on the left leg." During an interview on 6/26/19 at 4 p.m., the Medical Doctor (MD) evaluated the skin injuries to the left leg and stated the injuries would take time to heal because Resident 1 was taking anti-inflammatory medicine. A review of the Interdisciplinary (IDT) Notes dated 6/15/19, revealed no preventative measures for further skin injuries. During observation on 6/28/19 at 1 p.m., PT A brought in a new right knee immobilizer to Resident 1's room.	F 686		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726	**F 726** • Resident 27 has been discharged from the facility to the hospital as of 8/2/2019. Therapy, CNAs, LNs, and the nursing management team worked with this resident during his stay to accommodate his transfer needs and desires. Staff was in-serviced for this particular resident's transfer abilities on 7/2/2019.	8/31/19

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F 726	Continued From page 22 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing staff had appropriate competencies and skill sets to provide nursing services, to one of 16 sampled residents (Resident 27), when the facility did not in-service (train) its Certified Nursing Assistants (CNAs) on resident transfer techniques and did not ensure five of six CNAs were competent to assist Resident 27, who was wheelchair-bound, to transfer from the wheelchair to the toilet. This failure resulted in injury and pain to Resident 27, when in two separate instances CNAs transferred Resident 27 from his wheelchair to the toilet using an improper transfer technique. During one transfer, Resident 27 was placed on the edge of the toilet and pushed back against the toilet seat suffering a skin injury on his buttock, causing him pain and discomfort. During a second transfer,	F 726	• It is the policy of the facility to have sufficient nursing staff with the appropriate competencies and skills. The facility will ensure that CNA staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, including transferring dependent residents. • The systemic change the facility is implementing to ensure CNA competencies and skill sets is an annual training for CNAs regarding the facility policy of Transfer/Lift Techniques. The annual training will include how to complete basic transfer techniques (i.e. 2 person transfer with gait belt, mechanical lift transfers, Arjo maxi-move transfer, etc.). Additionally, an assessment of all new admissions or residents that have a change in condition that require appropriate transfer technique updates, will be completed. The appropriate and current transfer technique(s) will be in the plan of care and sent to the touchscreens so CNAs know. • The facility plans to monitor this POC with the DSD ensuring all staff are trained upon hire, annually, and as needed starting 7/12/2019. Skills checklists will be	

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F 726	Continued From page 23 Resident 27 was pushed against the toilet seat and his genitals became entangled in the toilet seat cover causing him extreme pain. Findings: A review of Resident 27's face sheet indicated he was admitted on 5/1/19, with diagnoses including generalized muscle weakness, lack of coordination, below-the-knee amputation of the right leg and unsteadiness. A review of Resident 27's Admission Assessment dated 5/1/19, indicated no skin injuries upon admission. A review of Resident 27's Minimum Data Set Assessment (MDS--An Assessment Tool) dated 5/8/19, indicated Resident 27 required extensive assistance and two or more persons to help when using the toilet and transferring between surfaces. During interviews on 6/24/19 at 10:56 a.m. and on 6/27/19 at 11:14 a.m., Resident 27 indicated he was wheelchair-bound and depended on staff to transfer him from the bed to the wheelchair and from the wheelchair to the toilet. Resident 27 indicated many of the facility's CNAs were not trained in how to assist dependent, elderly residents, like himself, to and from surfaces. Resident 27 reported two incidents in which he was injured because CNAs assisting him to the toilet used improper transfer techniques. Resident 27 reported these two incidents happened around middle of May 2019. The first incident Resident 27 reported, occurred when he needed to use the toilet, and two female	F 726	maintained in the employee file by the DSD. Additionally, the RCMs will be auditing resident charts weekly and discussing changes with the IDT. Findings will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	

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F 726	Continued From page 24 CNAs, whom Resident 27 indicated appeared to the be recently hired, came to assist him. Resident 27 stated the CNAs placed a gait belt (a belt placed around the waist of residents to assist in lifting and moving a dependent person), but did not use it during the transfer. Resident 27 stated the CNAs instead, grabbed him by the arms, lifted him from the wheelchair, and placed him at the edge of the toilet. Resident 27 reported the CNAs, realizing he was not at the center of the toilet, placed their hands on his hip area and pushed him back towards the center of the toilet. Resident 27 stated he felt pain on his buttocks when being pushed on the toilet, and it resulted in, what he described, as a friction injury to his right buttock. A review of Resident 27's Progress Note dated 5/19/19 at 7:37 a.m., indicated he reported discomfort on his buttocks. The note indicated Resident 27 stated, "Take a look at my bottom, I scrapped on Thursday evening when toileting..." The note indicated Resident 27 was assessed by Licensed Nurse N who indicated on the note Resident 27 had a, "1 cm (centimeter) x 1 cm oval shaped superficial abrasion on his right lower buttock...." A review of Resident 27's clinical record indicated the injury to his right buttock worsened and caused him pain. A Progress Note dated 6/27/19 at 1:11 a.m., indicated: "Resident was c/o (complaining of) pain and bleeding on right lower buttocks abrasion. Resident has an open area approx. 2cm x 2cm. It is open, bleeding, black around the edges..." Resident 27 reported the second incident happened the day following the first incident, also	F 726		

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F 726	Continued From page 25 in the evening shift (3 p.m. to 11 p.m.), and in similar circumstances as the first incident. Resident 27 reported he needed to use the toilet, and two female CNAs came to assist him. The CNAs placed a gait belt around him, but did not use it during the transfer. The CNAs instead, grabbed him by his arms, lifted him from the wheelchair and placed him at the edge of the toilet. Thereafter, the CNAs, holding onto his hips area, pushed him back towards the center of the toilet. When he was pushed back into the toilet seat, Resident 27 reported his penis and scrotum were caught in the toilet seat cover, and he felt extreme pain when his genitals were wedged against the toilet seat. Resident 27 reported: "They were really pushing hard... Pushing me against the toilet seat... I asked them to stop but they kept pushing." During an interview on 6/27/19, at 10:55 a.m., and at 2:26 p.m., the Director of Staff Development (DSD) indicated staff were trained to use gait belts when transferring residents and should not pull or push residents by the limbs when transferring them. The DSD stated the Physical Therapy Department in-serviced (trained) staff on the proper transfer techniques. During an interview on 6/27/19, at 3:14 p.m., the facility's Assistant Director of Rehabilitation indicated the preferred method for transferring dependent residents was by using a gait belt. She stated grabbing residents by their arms/limbs could cause injuries. She stated pushing residents on the toilet could cause skin injury. During an interview on 6/27/19, at 2:20 p.m., the Director of Nursing (DON) stated she could not identify the CNAs who were involved in the	F 726		

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F 726	Continued From page 26 incident where Resident 27 injured his right buttock. The DON stated any of the CNAs on duty could have participated in the transfer when Resident 27 was injured. The DON indicated many of the CNAs, working at the time of the incident, may be no longer be working with the facility. A review of the staffing sheets for the dates in which Resident 27 reported he was injured, 5/16/19 and 5/17/19, pm/evening shifts, indicated a total of six female CNAs on duty: CNAs D, E, F, G, H and I. During interviews on 6/27/19, at 10:55 a.m. and at 2:26 p.m., and on 7/2/19, at 9:05 a.m., the DSD stated CNAs, upon hire, were assessed for competency in how to transfer dependent residents. The DSD was asked for the records wherein the facility verified CNAs D, E, F, G, H and I were competent in transferring residents. The DSD indicated these would be found in the CNAs competency checklists and provided the competency checklists for five of the six CNAs: CNAs D, E, F, G and H. A review CNA D's competency checklist indicated she demonstrated competency in transfer techniques in May 2019. A review of CNA E's competency checklist indicated an undated, incomplete and unsigned document where it was not possible to ascertain CNA E had a competency and skills verification check. A review of CNA F's competency checklist indicated an incomplete document where the skills of toileting and transferring residents were	F 726		

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F 726	Continued From page 27 not marked as performed. A review of CNA G's competency checklist did not have her name on the competency checklist forms, and it was not possible to identify which staff those forms referred to. A review of CNA H's competency checklist did not indicate competency verification of transfer and toileting techniques of dependent residents. No competency checklist was provided for CNA I. A review of facility policy titled, "CNA Orientation/Skills Competencies," dated January 2018, indicated the following: "It is the policy of the Company that the hiring of new CNA's will require completion of a Skills Assessment checklist within the probation period of all CNA's new to the facility, regardless of past employment experience. This will serve as a tool during orientation and will give the Licensed Nurses the opportunity to assess the CNA's skills, and will be a tool for targeting areas needing improvement." During an interview on 6/27/19, at 2:26 p.m., the DSD was asked for records of the facility in-services (in-house training) for CNAs, on how to transfer dependent residents. The DSD provided records of CNA training of transferring residents using a sliding board, dated 6/5/19. No previous or additional training records on how to transfer dependent residents, were provided. During an interview on 07/02/19, at 08:23 a.m., CNA J indicated he/she had been assigned to care for Resident 27 and had not received any	F 726		

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F 726	Continued From page 28 facility training on how to transfer dependent residents, such as Resident 27. During an interview on 07/02/19, at 08:28 a.m., CNA K indicated he/she had been assigned to care for Resident 27 and had not received any facility training on how to transfer dependent residents, such as Resident 27. A Facility policy titled, "Transfer/Lift Techniques," dated January 2018, indicated: "All staff will be in-serviced when they are hired and annually thereafter in proper transfer techniques and use and care of lifts. In-services will also be given when new residents needing assisted transfers are admitted to the facility."	F 726		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761	**F 761** • The facility will ensure all drugs/medications are properly labeled per the facility policy "Medication Ordering and Receiving from Pharmacy", (medication policy) and professional principles, including properly labeled date of opening and expiration. Both bottles of lorazepam medication were properly labeled upon discovery during the survey. The 6/17 date	8/31/19

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F 761	Continued From page 29 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to label drugs according to professional principles, when the facility labeled one bottle of lorazepam (an anxiolytic medication) with an opened date which was unclear and did not label another bottle of lorazepam with the date it had been opened. The bottles of lorazepam indicated on their label they expired 90 days after being opened. The facility's failure to properly date the lorazepam bottles with the date they were opened, had the potential for residents to receive expired lorazepam. Findings: During an observation of the facility's main medication room on 6/26/19, at 9:25 a.m., with the Director of Nursing (DON), there were two opened bottles of Lorazepam Intesol 30 ml (milliliters). One bottle was marked as having been opened on, "6/17," and another bottle did not have the date it was opened. Both bottles indicated on their labels they were valid for 90 days after opening. During a concurrent interview, the DON was asked what the date, "6/17," meant, whether it meant June 2017 or June 17. The DON stated it was unclear. Upon consulting facility records, the DON confirmed the lorazepam bottle was opened	F 761	was in reference to June 17th 2019 not June of 2017 as the resident was not admitted during that timeframe. The other bottle that had no date was labeled upon discovery during survey by reviewing the narcotic order book and verifying the start date for that particular medication. • According to the facility's medication policy, all stored medications shall be labeled and maintained in compliance with State & Federal regulations. The medication label will contain the following information: Name of the prescribing physician; Drug name; strength; quantity; the date filled; the prescription number and the name of the issuing pharmacy; instructions, if any, regarding control and custody of the medication; and date of expiration. To further ensure the facility is in compliance with this policy and that all medications have a "use date" the facility has procured labels that were implemented for use on 7/8/2019. Staff was formally in-serviced on this process as of 8/26/2019. • The systemic change the facility is implementing will be to in-service	

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F 761	Continued From page 30 on 6/17/19, and should have been dated accordingly. The DON also confirmed the other lorazepam bottle, which was opened and undated, should have been dated with the date it was opened. Facility policy titled, "Medication Ordering and Receiving from Pharmacy," revised 3/4/14, indicated: "Each prescription medication label includes:.. (9) "Beyond use" (or expiration) date of medication."	F 761	LN staff in regard Medication Storage and Safety policy including the importance medication labels. A review of the medication policy and reference sheet for medication expirations will be given upon hire and annually. This process will be audited for compliance by the DON and Pharmacy Nurse Consultant on a quarterly basis. • The facility plans to monitor this POC with the DON and pharmacist. Audit results and corrective actions will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a nourishing and well-balanced diet that met nutritional needs and took into account resident preferences, to two of 16 sampled residents (Residents 3 and 42) when: 1) Resident 3 was not served a vegetable side and a salad side for lunch on 6/24/19; and, 2) Resident 42 was not offered an alternate meal for lunch on 6/24/19. These failures had the potential for Residents 3 and 42's nutritional needs not being met.	F 800	• F 800 • The facility will ensure each resident will be provided with a nourishing, palatable, and well balanced diet that meets residents' nutritional needs, that takes into account resident food/meal preferences. Resident 3's food preferences have been updated as of 7/3/19. Resident	8/31/19

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F 800	Continued From page 31 Findings: 1) A review of the lunch menu for 6/24/19, indicated fish, rice and broccoli. A review of Resident 3's meal ticket for 6/24/19, indicated Resident 3 disliked broccoli and requested a side salad. During an observation on 6/24/19, at 12:40 p.m., Resident 3 was eating lunch in her room, and her tray did not have a side of vegetable or a salad. During a concurrent interview, Resident 3 confirmed (and complained) she had not been served a vegetable side and a side salad, as she had requested. Resident 3 stated she loved salads. During an interview on 6/27/19, at 9:15 a.m., the facility's Nutritional Services Manager reviewed Resident 3's meal ticket and confirmed she should have been served an alternate vegetable (since she disliked broccoli) and a side salad (which she had requested) for lunch on 6/24/19. 2) During an observation on 6/24/19, at 1:05 p.m., Resident 42's lunch tray was removed from her room to a meal cart on the hallway. An inspection of Resident 42's lunch tray indicated she consumed less then 25% of her lunch. During an interview on 6/25/19, at 8:45 a.m., Resident 42 reported she did not like the food served for lunch on 6/24/19, and ate very little of the food items that were on the tray. Resident 42 stated staff collected her largely untouched food tray and did not offer a substitute or alternate meal for her.	F 800	42's food preferences have been updated as of 7/15/19. Both residents are being offered alternatives that are nourishing and well-balanced to meet their nutritional needs and preferences. Daily alternate meal options are included in the weekly menu and are in addition to a separate seasonal standard alternate menu; both menus are posted at the nurse's station, in the dining room, and in current resident rooms every week. • It is the policy of the facility to have the services of a Registered Dietitian (RD) to provide qualified professional interventions for new admissions and significant changes in residents related to dietary issues per state and federal regulations. The RD will complete an assessment for each new resident, or resident with a significant change. The RD will also provide food service program audits and/or reports, and will share this information with the appropriate facility staff. • To further ensure that residents are provided nourishing and well-balanced diets that meet their nutritional needs and preferences; the facility will be in-	

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F 800	Continued From page 32 A review of Resident 42's Nutrition Care Plan, dated 6/3/19, indicated, "Monitor PO intake [food/drinks taken orally], offer alternate item if intake is less than 75%." During an interview on 06/27/19, at 9:15 a.m., the facility's Nutritional Services Manager indicated, if residents do not eat a substantial amount of their meals, a substitute meal should be offered. Facility policy titled, "Dietary Services: Dining," dated 1/2018, indicated: "It is the policy of the Company that residents will receive well-balanced, nourishing, and palatable meals and snacks that meet their nutritional and special dietary needs."	F 800	servicing nutritional services staff and CNAs in how/when to provide alternate meal options as outlined in the facility Nutrition Risk Policy (i.e. when 50% or less of a meal is consistently consumed by a resident). This in-service occurred 8/27/2019 and the RD was responsible for training staff in collaboration with the DSD, on the policy and answering questions as they arise. In addition to educating the staff in how/when to provide alternate meal options, the RD will ensure that weekly menus and alternate menus are posted at the nurse's station, in the dining room, and in current resident rooms every week as well as provided upon admission to new residents. Alternatives are noted on the weekly menus.	
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its policy on food brought into the facility by family and visitors, for one un-sampled resident (Resident 52), when Resident 52 had fruit in her room, not provided by the facility, which was not labeled with Resident 52's name, room number and date it was brought in. This failure had the potential for Resident 52 to consume unsafe food.	F 813	• The facility plans to monitor this with the RD performing resident substitute/alternate meal audits. Resident interviews and preference reviews will be completed during care conferences. Audit results and corrective actions will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be	

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	555639	A. BUILDING _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF NAPA VALLEY	1900 ATRIUM PARKWAY NAPA, CA 94559

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F 813	Continued From page 33 Findings: During an observation on 6/24/19, at 11:45 a.m., there were bags of cherries, grapes and strawberries next Resident 52's bed. The bags containing the fruit were not labeled with Resident 52's name, room number or date they were brought in. During an observation and interview on 6/24/19, at 12:20 a.m., the Director of Nursing (DON) confirmed the fruits were not provided by the facility and were not labeled with Resident 52's name, room or date. The DON removed the fruit from Resident 52's room. A review of facility policy titled, "Food Brought Into Facility by Family and Visitors," last revised 3/2018, indicated: "Brought-in food must be covered, labeled with resident's name and room number and dated."	F 813	determined by the QAPI committee in January 2020. **F 813** • The facility will ensure its personal food policy, (Food Brought into Facility by Family and Visitors) will be followed. Resident 52's grapes and strawberries were disposed of upon surveyor notification. The "Dietary Services: Food Brought Into Facility by Family/Visitors" policy was reviewed with the family and resident on 7/8/19. • Per the personal food policy of the facility, family/visitors are welcome to bring in food for the resident providing it meets food safety requirements. The policy also outlines that facility staff will educate family/visitor in a language they understand, about the resident's diet texture and/or therapeutic diet modifications, and that food may be brought in for a resident that was not prepared in the facility kitchen. Family/visitor will be requested to notify the charge nurse when bringing in food to the resident and the brought-in food must be covered, labeled with resident's name and room number and dated. The facility staff will store food brought in by family/visitor	8/31/19
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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F 842	Continued From page 34 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-. (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	In a designated section in a refrigerator in the health center servery. Brought-in food will be easily distinguishable from the facility food. Brought-in outside food stored in the refrigerator, will be discarded 3 days after the date it was brought in. Food or beverage past the manufacturer's expiration or "used by" dates will be discarded as well. Nutritional Service Aides in addition to the RD will monitor food on a daily basis to ensure timely disregarding. Additionally, the RD in collaboration with the DSD will be in-servicing the CNAs and LNs on the "Dietary Services: Food Brought Into Facility by Family/Visitors" policy upon on 8/26/2019 and 8/27/2019. • The systemic change the facility is implementing to ensure family/visitor food meets safety requirements includes the RD offering to educate residents on a bi-monthly basis during Resident Council Meetings of the personal food policy. The "Dietary Services: Food Brought Into Facility by Family/Visitors" will be added to the admission packet and discussed by the SSD during admission effective 8/23/2019. Additionally, the RD in	

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F 842	Continued From page 35 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain accurate medical records for one of 16 sampled residents (Resident 42), when the facility documented Resident 42 ate 90% of her lunch on 6/24/19, when in fact, Resident 42 ate less than 25% of her lunch. This failure resulted in Resident 42's medical record not properly representing the health conditions of Resident 42. Findings: During an observation on 6/24/19, at 1:05 p.m., Resident 42's lunch tray was removed from her room to a meal cart on the hallway, by staff. An inspection of Resident 42's lunch tray indicated less than 25% of the food had been consumed. During an interview on 6/25/19, at 8:45 a.m., Resident 42 reported she did not like the food served for lunch on 6/24/19, and ate very little of her tray's contents. A review of Resident 42's meal consumption record for 6/24/19, "Daily Charting for: Monday,	F 842	collaboration with the DSD in-serviced the CNAs and LNs on the "Dietary Services: Food Brought Into Facility by Family/Visitors" policy upon hire and annually. • The facility plans to monitor this POC with the RD, DSD and SSD, with any corrective actions being reported monthly during QAPI Committee meeting through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020. **F 842** • The facility will ensure all information contained in the resident's medical record be kept confidential. The facility will ensure accurate medical records and documentation will be maintained for Resident 42. • To ensure all residents have recorded meal/food consumption accurately, CNA staff was in-serviced by the DSD on accurately recording meal/food consumption per the Nursing Services Documentation policy on 8/27/2019. It is the policy of the facility that documentation of all	8/31/19

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F 842	Continued From page 36 June 24, 2019," indicated Resident 42 consumed 90% of lunch on 6/24/19. A review of facility policy titled, "Nursing Services Documentation," last revised 3/2015, indicated: "It is the policy of the Company to assure that nursing services documentation is performed in a manner to meet or exceed the state and federal regulations as well as to assure that the needs of the residents are met through proper representation of their condition in the health information record."	F 842	nursing care and observations, assessments and treatments, and effects be accurate, understandable, timely, pertinent and held in confidence. • The systemic change the facility is implementing is to complete weekly random audits of the meal consumption records to resident trays. The DSD, in collaboration with the RD, will ensure education is provided upon hire and annually on complete and accurate documentation of patient intake. • The facility plans to monitor this POC with the DSD auditing the food/meal consumption documentation. Any corrective actions will be reported monthly during QAPI Committee meetings through January 2020 to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	**F 880** • The facility will establish and maintain an Infection Prevention and Control Program (IPCP), to prevent the development and transmission of communicable	8/31/19

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F 880	Continued From page 37 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	disease and infection. A new DSD/Infection Preventionist (IP) was hired on 6/3/19, to manage and maintain the Infection Prevention and Control Program (IPCP). All elements of the IPCP requirement will be met as stated in CFR (483.80 (a) through (f), which includes surveillance of infections, a system for recording identified incidents, corrective actions taken, monitoring corrective actions taken and antibiotic stewardship. Resident 28 has been discharged 7/6/19. For Resident 28 the antibiotics started on 6/22/2019 and completed on 6/28/19. The IC plan report for resident 28 was implemented and completed and reported on at QAPI in July. Resident 23 was treated for a UTI per the physician's request; she was treated prophylactically. The antibiotics where started 6/29/2019 and discontinued on 7/4/2019. She is encouraged daily to increase her intake of fluids to reduce the chance of future UTIs. • The facility's policy regarding infection prevention and control is to establish and maintain a comprehensive IPCP that establishes a facility-wide system for the prevention, identification,	

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F 880	Continued From page 38 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to maintain an infection prevention and control program, that included: Surveillance of infections; a system for recording identified incidents; development and implementation of corrective actions; monitoring corrective actions taken; and antibiotic stewardship. This failure resulted in an increased risk for development and transmission of communicable diseases and infections, in a population of elderly residents with complex medical conditions. Findings: During an interview with Licensed Nurse C, on 6/24/19, at 4:05 p.m., she stated, if a resident in her care had a new symptom of illness or change in mental or physical function, she would call the resident's doctor. LN C stated she would document the change that occurred and the outcome of the conversation with the doctor in the resident's Electronic Medical Record (EMR). LN C stated she would tell the nurse scheduled to relieve her, during the change of shift report. When asked if the facility had requirements regarding what information must be provided to the doctor when staff call about changes to the resident's condition, she stated, "No," not that she was aware of. During an interview with the Director of Nursing (DON), on 6/27/19, at 11:30 a.m., she stated the Director of Staff Development (DSD) was also the Infection Preventionist (IP) for the facility. The	F 880	investigation and control of infections of residents, staff and visitors that is based upon facility assessment, best practices and regulatory compliance for the goal of quality systems for care. The IPCP includes a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services. Written standards, policies, and procedures for the IPCP include: surveillance, reporting, standard and transmission-based precautions, when and how isolation/precautions should be used for a resident, respiratory hygiene/cough etiquette, environmental cleaning and disinfection. A comprehensive audit of residents within the facility as of 7/3/2019 was completed to ensure all infections are managed per standards of practice and in compliance with the IPCP P&P. In addition, in-services with the LN staff regarding the above noted P&Ps by the IP, an infection tracking log began on 8/21/2019. The next IPCP training was held 8/28/2019; additional trainings will be	

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F 880	Continued From page 39 DON stated the employee was new to the facility. The DON confirmed questions related to the facility's infection control and antibiotic stewardship programs should be directed to the DSD/IP. During an interview with the Infection Preventionist (IP), on 6/27/19, at 4:08 p.m., she stated the facility's Infection Prevention and Control Program (IPCP) had been managed by an employee who was no longer at the facility. The IP stated she was working on restarting the program. The IP reviewed the IPCP documents and found a map of the facility with infection data and analysis, dated 4/19. The document indicated an action plan which included four corrective actions. The IP was unable to provide any documentation for the implementation of the action plan. The IP confirmed there was no documentation of infection surveillance or data analysis for May or June. The IP was unable to provide evidence on ongoing antibiotic stewardship. During an interview with Licensed Nurse A (LN A), on 6/28/19, at 11:33 a.m., she stated she had worked at the facility for over four years. LN A stated she was familiar with the procedures after a resident had a change in their condition. The procedure did not include a data collection tool with symptom analysis based on nationally-recognized surveillance criteria. The procedure also lacked a tool to promote antibiotic stewardship when reporting the change in condition to the doctor. During an interview with the Infection Preventionist (IP) and the Administrator, on 6/28/19, at 2:12 p.m., they described the	F 880	completed on a quarterly basis at a minimum with all LN staff. The IP will be responsible for ensuring all LN staff receive the training and that the concepts of the IPCP are reiterated; trends or current concerns will be further addressed used to educate the LN staff. • The measures and systemic changes the facility is implementing is as follows: annual review of, and updates to, IPCP as national standards change; the IP has implemented the IPCP P&P, Infection Control Surveillance P&P (including the IC tracking log) for the facility and is be responsible for sustaining it. • The facility plans to monitor this POC with the IP, DON, RCMs, LN Nurse Consultant, Medical Director and Pharmacist. The IP will ensure all staff are provided education on the IPCP P&P upon hire and annually. The DON, RCMs, IP, Medical Director and Pharmacist will review facility infections to ensure compliance with the IPCP P&P monthly through January 2020. Infection control corrective actions will be reported monthly during QAPI Committee meetings to ensure	

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F 880	Continued From page 40 processes to be used for infection control and prevention. The IP stated she would review resident orders for antibiotics and review the resident alert charting notes to gather and log facility infections. The IP stated she planned on performing root cause analysis to determine what improvements the facility could make to reduce the risk of further infections. The IP stated she would create a monthly surveillance report with infection rate. The IP stated quarterly action plans would be based on the monthly reports. The IP confirmed she had not performed any duties as an IP since her date of hire. The Administrator confirmed there were no acting or interim staff tasked with maintaining the program. No employee process surveillance was discussed or provided for review. No documentation showing the action plan from 4/19, was implemented, was provided. When asked if the facility was aware Resident 23 and Resident 28 were both being treated for Urinary Tract Infections (UTI), both the IP and the Administrator reviewed the data and were unable to provide evidence the facility infection control plan had been implemented for either resident. During a review of Resident 23's clinical record, the Infection Report, dated 1/12/19, indicated Resident 23 had a facility-acquired UTI. The report indicated urine analysis was performed. The treatment listed was a broad spectrum antibiotic, started on 1/23/19. The sensitivity section, where the laboratory documented more specific antibiotics which would work, was left blank. No follow-up or monitoring was documented for this infection. During a review of Resident 23's clinical record, the Infection Report, dated 6/23/19, indicated	F 880	POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	

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F 880	Continued From page 41 Resident 23 had a facility-acquired UTI. The report indicated urine analysis was performed. The treatment listed was a broad spectrum antibiotic, started on 6/29/19. The sensitivity section, where the laboratory documented more specific antibiotics which would work, was left blank. The Constitutional Criteria section was left blank. The Symptoms section required two criteria be present; the report indicated only one present. The Notification section was left blank. The entire follow-up section was left blank. No follow-up or monitoring was documented for this infection. During a review of Resident 28's clinical record, the Infection Report, dated 5/21/19, indicated Resident 28 had a facility-acquired UTI. The treatment listed was a broad spectrum antibiotic, started on 5/21/19. The sensitivity section, where the laboratory documented more specific antibiotics which would work, was left blank. No IP involvement was documented. During a review of Resident 28's clinical record, the Infection Report, dated 6/22/19, indicated Resident 28 had a facility-acquired UTI. The treatment listed was a broad spectrum antibiotic, started on 6/22/19. The sensitivity section, where the laboratory documented more specific antibiotics which would work, was left blank. The symptoms section was incomplete, with required sub criteria left blank. The report indicated no follow-up documentation. There was no mention of repeat infection, with the same antibiotic used. No IP involvement was documented. The facility policy and procedure titled, "Infection Prevention and Control Program (IPCP)," last revised 11/17, indicated the facility recorded	F 880		

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F 880	Continued From page 42 incidents identified under the facility's IPCP and the corrective actions taken by the facility. The facility policy and procedure titled, "Infection Control Surveillance," last revised 11/17, indicated both process and outcome surveillance would be utilized. The policy further indicated the facility would monitor the implementation of the IPCP. Data analysis would assist the facility in comparing current and past infection control surveillance. The policy indicated facility-acquired infections would be monitored and analyzed with recommendations sent to the appropriate departments to reduce the amount of infection.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to implement an antibiotic stewardship program. This failure resulted in an increased risk for: Adverse drug events; ineffective treatment from inappropriate antibiotic use; and development of antibiotic-resistant organisms, in a population of elderly residents with complex medical conditions. Findings:	F 881	**F 881** • The facility has an established Infection Prevention and Control Program (IPCP), including an Antibiotic Stewardship Program (ASP) and policies to optimize the prescribing processes including the selection, dosing and duration of antibiotic therapy in individual residents to improve resident outcomes and reduce adverse drug events, including secondary infections. • The facility will follow the ASP policy which aids in the identification of residents with a suspected infection or use of antibiotics by timely and accurate recognition, assessment and communication in a resident's condition to the resident's primary health provider.	8/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555639	A. BUILDING _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF NAPA VALLEY	1900 ATRIUM PARKWAY NAPA, CA 94559

(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 881	Continued From page 43 During an interview with the Infection Preventionist (IP), on 6/27/19, at 4:12 p.m., she stated the facility had an antibiotic stewardship program. The IP stated reports from laboratory results and new antibiotic order reports, were used in the process. The IP was unable to find any reports showing antibiotic stewardship since she started working at the facility. The IP was unable to provide any documentation which showed interaction with the facility and prescribers, to encourage antibiotic stewardship. During an interview with the Infection Preventionist (IP) and the Administrator, on 6/28/19, at 2:12 p.m., they were unable to provide any documentation of antibiotic stewardship education plans created by an antibiotic stewardship team, based on collected data. During a review of Resident 28's clinical record, the Infection Tracking section indicated Resident 28 was diagnosed with a Urinary Tract Infection (UTI) on 5/21/19. Antibiotic treatment was ordered with a broad spectrum antibiotic. Laboratory screening for more specific antibiotic therapy was not completed. The medication was not changed to a more specific medication. Resident 28 was diagnosed on 6/22/19, with a second UTI; the same antibiotic was ordered. There was no documentation of monitoring for adherence to the facility antibiotic stewardship procedures. The facility policy and procedure titled, "Antibiotic Stewardship," last revised 11/17, indicated the facility would establish and maintain a program which provided procedures for antibiotic prescribing, monitored antibiotic use, analyzed	F 881	Utilization of the Infection Tracking in the residents' EHR will allow LNs to document symptoms as it uses the standardized McGeer Criteria for infections. • Systemic changes to be implemented include the IP being notified by the nursing staff on a suspected infection or the start of antibiotics on a daily basis. The IP will also check the 24 hour report/Alert Charting Log for any residents that are monitored for infection symptoms or the start of antibiotics. The DSD/IP will run reports on the EHR for antibiotics prescribed on a weekly basis to ensure no resident was missed for that week. An infection tracking log began on 8/21/2019 to also aid in tracking. A monthly meeting with DON, IP, Pharmacy Consultant, HCA, direct care staff, and Medical Director will be held to ensure the Antibiotic Stewardship Program is followed and identify any needed corrective action to ensure compliance. The IP, in collaboration with the DON, will ensure nursing staff are provided education on the IPCP P&P as well as the Antibiotic Stewardship Program upon hire and annually.	

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F 881	Continued From page 44 outcome data and provided education on the responsibility of implementation for antibiotic stewardship. The policy further indicated an antibiotic stewardship team would meet, at least quarterly, to review data, communicate outcomes, and oversee ongoing education.	F 881	• The IP will report monthly during QAPI Committee meetings through January 2020 for trends and any infection control corrective actions or ASP corrective actions to ensure POC is achieved and sustained. The continued frequency of the audit will be determined by the QAPI committee in January 2020.	