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

PRINTED: 10/31/2014
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
	056280	A. BUILDING _____ B. WING _____	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HEALTHCARE CENTER OF OAKLAND	2919 FRUITVALE AVE OAKLAND, CA 94602

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a Recertification survey conducted between 10/13/14 and 10/17/14. A complaint and an entity reported incident were investigation during the survey. Complaint incident number: CA00416037 Facility reported incident number: CA00416046 Representing the Department were the following Health Facility Evaluator Nurses: 25206, 32427, and 33833. The census was 87 (including 1 bed hold) at the time of the survey. No deficiencies were issued for the complaint and the entity reported incident.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provision of Health and Safety Code Section 1280 and 42 C.F.R. 483. Please accept this POC as our credible allegation of compliance.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the facility's policy and procedures to screen and/or provide appropriate training for six out of six employees on prevention of abuse. This failure could potentially place all residents and staff at risk for being abused due to the lack of complete training and screening for employees. Findings: During an interview and concurrent employee file	F 226	**F226 - Develop Implement Abuse Neglect, etc. Policy** **Corrective Action for those found to be affected.** Reference checks completed for the following staff: LVN hired on 6/2/2014, LVN hired on 4/19/2014, Receptionist hired on 8/6/2014, CNA hired on 5/14/14, and CNA hired on 5/14/2014, CNA hired on 9/30/14. Reference check for ADON hired on 6/24/13 Abuse training provided by the DSD to the following staff: Receptionist hired on 8/06/14, CNA hired on 6/24/13. Post tests were completed by 11/11/2014 RECEIVED NOV 14 2014	11/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE [redacted] (X6) DATE [redacted]

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.

[redacted]

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F 226	Continued From page 1 review on 10/17/14 between 9:30 a.m. and 11:15 a.m., Director of Staff Development/Infection Control Coordinator (DSD/ICC), while in the presence of Quality Assurance Nurse Consultant (QANC), and Administrator (ADM), verified and confirmed that the reference check (from previous employers and/or current employers) for six out of six employees was not performed and two out of six employees did not receive abuse training and mandated abused reporter training. 1. Licensed Vocational Nurse (LVN), she was hired on 6/2/14, showed that no reference check was performed. 2. Licensed Vocational Nurse (LVN), she was hired on 4/19/14, showed that no reference check was performed. 3. The receptionist was hired on 8/6/14. The record showed no reference check was done and the abuse training/mandated reporting was not done. DSD/ICC stated he is a receptionist and hardly did anything for him because he only works part-time on the weekend. 4. Certified Nursing Assistant (CNA) was hired on 5/14/14, showed that background checked was done on 8/6/14 but it was after 84 days since he started working. No reference check was performed. 5. Certified Nursing Assistant (CNA) was hired on 9/30/14, showed that no reference check was performed. No evidence of abuse training and mandated reporting was on file. DSD/ICC stated that "They watched the videos and discuss the content" but no evidence of evaluation such as post-test to check for the knowledge was done. 6. Acting Director of Nursing (ADON) was hired on 6/24/13, showed no reference check was on file. DSD/ICC stated that she checked the references for these potential employees before she even	F 226	**Identification of other residents having the potential to be affected and corrective action** Residents have the potential to be affected. In-service training on hiring policy and abuse provided to DSD by Administrator by 11/11/2014. Employee files were reviewed and those that require abuse training or background information were completed 11/11/2014 **Measure in place / Systematic Changes to ensure that same practice does not recur:** Employees to be hired will have their background checks and reference checks completed prior to hire. The DSD will conduct an interactive in-service on Abuse and mandatory reporting to new hires during their orientation and annually thereafter. Administrator/ or designee will review and sign off on new hire packets to ensure all documents and trainings have been completed. **Monitoring:** The Administrator will routinely review all new hire packets. Findings will be reviewed at Quality Assurance Committee quarterly for follow up and further recommendations.	

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F 226	Continued From page 2 considered scheduling an interview; she was unable to show documentation to verify that she did a reference check. She had a check-off list for each employee that she checked off to show that screening and training were done but no proper documentation or notes indicated when or how it was done. According to the facility's policy and procedure titled, "Abuse, Prevention Of" last reviewed on 2007, showed under: A "Procedure 1. All CAN's (sic) will be properly screened for criminal background and approved by the Department of Health Services, through use of their CNA Abuse registry and Certification Verification program. 2. Employees to be hired other than CNA's will have their previous employment and employment references verified prior to hire. This will be completed based on the information provided on the application. B. TRAINING: All employees/caregiver will be oriented to their role in abuse prevention as mandated reporters and that abuse will not be tolerated in this facility." According to facility's policy and procedure titled "FACILITY INSERVICE EDUCATION PROGRAM" showed that: 1. The Director of Staff Development will be responsible for the educational needs of the staff including: assessment, planning, implementation, and evaluation of education provided. 5. When inservice videos and/or audio tapes are utilized to train nursing assistant, the instructor she be present for discussion, clarification, and evaluation. 11. A record of each inservice shall be maintained by the Department of Staff Development."	F 226		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		

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F 252	Continued From page 3 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide housekeeping and maintenance services to maintain some residents' bathrooms in a sanitary, clean and comfortable environment. This failure exposed residents to live in an environment that was not homelike. During the environmental tour with the ESD (Environmental Service Director) on 10/15/2014 at 9:30 a.m., the following were noted: 1. Room 7's toilet seat had a deep and rough gouged area towards the front of the seat, measuring approximately 5 by 4 inches. The gouges contained black material. In an interview on 10/15/2014 at 10:30 a.m., the ESD stated that he was unaware of this problem and "we can replace that". 2. Room 22's bathroom had a three foot by four foot unpainted, patched and stained area on the ceiling, above the bathroom door. In an interview on 10/15/2014 at 10:40 a.m., the resident 21 stated, "That's been here ever since I've been here". He stated that he had been in the facility for about 5 years. He also stated "they can paint it." The ESD stated that he was not aware of this particular problem. 3. Room 26's bathroom had two patched and unpainted holes, approximately one foot by a half foot. Both holes located on the opposite wall from the sink. There was also an approximately 2 inch oval hole on the one of the bathroom doors.	F 252	**F252 Safe/Clean/ Comfortable/Homelike Environment-** **Corrective Action for those found to be affected:** Room 7 toilet Seat with rough area was replaced. Room 22's bathroom's unpainted patched area has been painted. Room 26 two patched area's has been painted. Oval hole on the door has been patched and painted. **Identification of other residents having the potential to be affected** Other Resident areas have the potential to be affected. Administrator and Maintenance supervisor will complete a facility Environmental rounds and any area affected by the same deficient practice will be corrected by 11/11/2014 **Measure in place / Systematic Changes to ensure that same practice does not recur:** Maintenance department was in-serviced by DSD regarding completion	11/11/14

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F 252	Continued From page 4 In an interview on 10/15/2014 at 10:50 a.m., the ESD stated that he was aware of those patches because he patched them but had not painted them yet. He stated that he was unaware of the hole on the door and that must be new.	F 252	of timely repair and tracking by 11/11/2014 Staffs were in-serviced by DSD on utilizing maintenance log to track facility repairs by 11/11/2014	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility failed to: 1. provide enough oxygen to Resident 4 while he was on a non-rebreather mask (NRB). Resident 4 was administered oxygen through a non-rebreather mask at lower than recommended flow rate. This failure prevented the proper functioning of the mask which had the potential to have resident 4 rebreathe carbon dioxide and not receive enough oxygen. 2. follow a physician's order to make sure Resident 6's lab work being done on timely. This failure could potentially result in delayed care and treatment to the resident. Findings: 1. On October 16 2014 at 8:27 a.m., the surveyor observed a medical emergency in progress, where Resident 4 was being treated for an alteration in his level of consciousness. Resident 4 received 15 liters of oxygen per minute through a non-rebreather mask (NRB). The surveyor observed the DON (Director of Nursing) entered the resident's room at 8:29 a.m. After a short while she asked how much oxygen the resident	F 281	Maintenance will check maintenance log twice daily. **Monitoring to ensure resolutions are sustained:** Administrator/designee will monitor logs and over all maintenance of the facility through routine inspections with maintenance department on a weekly basis. Results will be reported to the Quality Assurance Committee quarterly for follow up and recommendation. **F281 Services Provided Meet Professional Standards-Corrective Action for those found to be affected:** Resident 4 oxygen liters and route of intake were questioned. Oxygen liters and route for oxygen were clarified at time of survey. Resident 6 lab orders were in question in regard to completion by surveyors. Physician contacted, clarification obtained. Labs completed and results communicated to physician. Resident 6 Phenytoin serum concentrate level and albumin lab	11/11/14

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F 281	Continued From page 5 was on to no one in particular. "Is he on two or four?" she asked. Not receiving an answer, she looked at the oxygen tank regulator and said "we need to turn it up." She proceeded to turn down the oxygen flow from 15 to 6 liters per minute at 8:30 a.m. At 8:41 a.m. after stating that the resident should be on 4 liter, she readjusted the oxygen regulator setting to 6 liters instead. At 8:41 a.m. the fire department paramedic arrived and increased the flow back to the original 15 liters stating it out loud. In an interview on 10/16/2014 at 9:50 a.m., the DON was asked to explain why she reduced the oxygen flow to 6 liters and she stated that she thought that Resident 4 was on a nasal cannula, "later I realized that he was on a Non rebreather." She was asked why she readjusted the oxygen flow to 6 liters a second time. She stated again that she thought the resident was on a nasal cannula and "later I realized he was on a NRB but I must have not cracked it up". She was asked if there were any potential problems with administering oxygen through a NRB at 6 liters per minute. She was unable to answer the question. A review of the facility's Oxygen policy and procedure, last revised in November 2012, revealed that oxygen through the NRB should be administer at minimum of 12 liters per minute. According to the textbook of basic nursing (9th ed.) the recommended rate at which a NRB should be set is 12 liters per minute and that "the correct flow rate prevents the client from rebreathing his or her own carbon dioxide." 2. Resident 6 was re-admitted to the facility on 4/15/14 with multiple diagnoses that include convulsion (or seizure is used interchangeably, the physical findings and/or changes in behavior that happens after an event of irregular electrical	F 281	order were in question in regards to their completion. During survey orders were clarified and carried out. Resident has a history of refusing labs. Residents chart updated with IDT note discussing risks and benefits in relation to refusal of lab draws. Plan of care updated. As of 11/11/2014 **Identification of other residents having the potential to be affected** Residents who receive oxygen have the potential to be affected. Nursing supervisor will review residents with order for oxygen and any resident affected by the same deficient practice will be corrected. Residents who require lab draw have the potential to be affected. Nursing supervisor will review residents with order for lab draw in the last 30 days. Physician will be notified of any residents who did not have their labs done as ordered. **Measure in place / Systematic Changes to ensure that same practice does not recur:** DON will In-Service LN on the policy and procedure regarding labs and oxygen administration by 11/11/2014. DON/ or designee will review lab request daily to ensure labs are completed as ordered. Resident's Physician will be notified of resident's refusals for lab draw.	

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F 281	Continued From page 6 activity in the brain). Resident 6's medication included Dilantin (or Phenytoin - medication used to control/prevent/treat seizures) capsule 150 mg two times a day, was started on 4/16/14. Physician's order dated 8/25/14 showed a blood test to check the level of Phenytoin serum concentration level and albumin on 9/10/14 and 3 months later. During an interview and concurrent record review on 10/15/14 at 1:05 p.m., Physician 1 while in the presence of Acting Director of Nursing (ADON), Physician 1 stated he would like to monitor the phenytoin level every six months to make sure that the level of medication was at the therapeutic range (certain level of medication in the blood to get right effect), because of its narrow therapeutic index. ADON stated that when she received the physician's order for the blood test. ADON stated that she filled out the laboratory slip to order the blood test, called the laboratory to let them know that Resident 6 needs a blood test. ADON took the lab binder (binder used to put in the all ordered laboratory test) from the shelf to review if Resident 6 had blood the blood test. ADON was unable to find the laboratory slip and confirmed that no blood test result was on file for Resident 6. ADON stated that maybe the resident refused to get her blood drawn because they "Have the right to refuse" and she refused treatment a lot. When asked what information was given to the resident before the blood test was performed such the reason for the blood test, ADON was not able to answer. ADON stated that if the lab comes in to draw the resident's, they would just get the lab slip from the binder. If the resident refused then they would not know unless the lab stopped by to let the nurse know that the resident refused. If the lab did not notify the nurse then they would not know that the lab was not drawn.	F 281	**Monitoring to ensure solutions are sustained:** Medical records/Designee will conduct weekly lab audits to ensure labs have been carried out and provide findings to DON/designee for follow up. DON will review 3 lab orders weekly to validate that results have been received and physician have been notified of refusal for lab draw. DON will check 3 residents with order for oxygen weekly to ensure oxygen is delivered at the recommended flow rate. Findings will be reported to the Quality Assurance meeting quarterly for evaluation and further recommendations.	

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F 281	Continued From page 7 ADON was unable to show that Resident 6 refused the blood test. When asked who should follow up on the blood test, ADON stated that it was the nurse's responsibility to follow up. ADON agreed that if the resident refused the nurses should educate resident and document on the nurse's notes, and notify the doctor. About half an hour later ADON presented two laboratory slips with dates of 9/10/14 and 12/10/14, stated that these were the lab slips that she filled out when she ordered the test, which showed that no follow up was done after the labs slip was filled out. Review of the facility's policy and procedure titled "Lab work, ordering & Reporting" last revised on 11/12 showed "It is the policy of this facility to obtain lab work and report lab results in a manner to ensure resident health care needs are met and addressed timely." Under "Procedure: Nursing Responsibility: 1. The licensed nurse will note physician's orders for lab work .... 5. If the resident refuses to have a blood draw or other lab done, the nurse will explain the reason for the test and the ramifications of refusal. The nurse will notify the resident's physician of refusal, and develop plan of care. "	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	**F309 Provide Care Services for Highest Wellbeing-** **Corrective Action for those found to be affected**	11/14/14

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F 309	Continued From page 8 by: Based on observation, interview, and record review, the facility failed to: For Resident 6, the facility failed to assess the resident pain during her treatment. This failure resulted in that Resident 6 suffered pain during her dressing change. For Resident 8, the facility failed to follow the physician ' s order to get lab work done for the resident. This failure could potentially result in delayed care and treatment to the resident. Findings: 1. During treatment observation and concurrent interview on 10/15/14 at 10:00 a.m., Licensed Vocational Nurse (LVN) 1 stated that Resident 6 has a pressure ulcer (wound to the skin and underlying tissues caused by persistent pressure) on her right leg, while preparing the treatment orders (dressing change). In the room Resident 6 was on her bed laying slightly tilted on her right side. During the treatment, when LVN 1 gently remove the dressing from the pressure ulcer, at this time, Resident 8 was holding on the side rails and saying on a low voice "Ouch" multiple times. When LVN 1 gently lifted Resident 6's right leg to remove the dressing on the inner side of the right leg, she was frowning. LVN 1 recognized that Resident 6 was having pain; he stopped and took a few seconds to give Resident 6 a break. During this time LVN 1 did not assess the resident pain or offered any pain relieving intervention to the resident. After the break, LVN 1 told Resident 6 that he would continue with the dressing change. LVN 1 cleaned the pressure ulcer with normal saline (NS-sterile solution of water and salt), which added Resident more pain. Resident 6 ' s hands were holding on to the side rails of the bed, and saying "Ouch" and/or calling the LVN 1's name in a low voice. After cleaning and gently pat	F 309	Resident 6 experienced pain during a dressing change. Physician orders were not followed related to resident 6 medications. Pain Evaluation completed for resident 6 during survey. LVN 1 was provided 1 on 1 in-service by DSD on facility policy and procedure for evaluating pain. LVN 1 provided in-service on following doctor's orders. LVN 1 provided in-service on chronic pain. LVN 1 provided in-service on wound treatments LVN 1 Provided in-service on communication with residents. Pain Evaluation was completed for resident 6 during survey. LVN 1 was provided 1 on 1 in-service by DSD on facility policy and procedure for evaluating pain by 11/11/2014 Resident 8 lab work was clarified by physician and completed per physician order during survey. CEI was contacted by ADON regarding plan of care provided at their facility. Lab results were communicated by ADON to CEI regarding residents lab results related to hematuria during the survey. Resident 8 Physician's order for suprapubic catheter was clarified to indicate when the supra pubic catheter will be changed and who will be responsible in changing the catheter.	

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F 309	Continued From page 9 drying with gauze, LVN 1 applied the medication with a tongue depressor (Popsicle stick) applied the new dressing to cover the pressure ulcer. Resident 6's face was frowning until LVN 1 was finished with dressing change. Review of Resident 6's clinical records showed that Resident 6's was readmitted to the facility on 4/15/14 with multiple diagnoses that included pressure ulcer and chronic pain. Last pressure ulcer assessment from AmeriWound (group of physician and specialist that provide comprehensive wound care and treatment) dated 10/7/14 showed that Resident 6 has right lateral leg pressure ulcer stage IV (the wound depth extend to exposed bone, tendon or muscle) with measurements of 4.5 centimeter (cm) long x 1.0 cm wide x 0.3 cm deep. Resident 6's treatment order for the pressure ulcer was "Cleanse right leg wound with normal saline. Pat dry. Apply Santyl to wound daily. Cover with dry clean dressing." Besides Resident 6 has a pain medication, "Fentanyl patch 72 hour apply patch transdermally on time a day every 3 days for Pain Management, she also has "Dilaudid tablet 4 MG Give 1 tablet by mouth every 3 hours as needed for breakthrough pain" (Dilaudid is a narcotic pain reliever). According to Resident 6's care plan for pressure ulcer, one of interventions was to "Administer analgesia as per order. Give ½ hour before treatment." In an interview on 10/15/14 at 10:40 a.m., Resident 6 stated that she had pain during the treatment with level of 7 out of 10 (pain assessment tool that uses 0 -10; from 0 indicates no pain and 10 which indicates worst pain imaginable, level of 7 indicates moderate to severe pain). Resident 6 stated that she was not offered or given a pain medication before the dressing change. She stated that she did not like	F 309	CEI was contacted by the ADON on during survey to obtain the documentation regarding the last time the supra pubic catheter was changed. **Identification of other residents having the potential to be affected and corrective action:** Other residents receiving wound care treatment have the potential to be affected. DSD observed the Treatment nurse provide treatment to these residents by 11/11/2014 and no other resident was affected by the same deficient practice. Other residents receiving services from CEI and have a urinary catheter and lab orders have the potential to be affected. ADON completed a record review of these residents and no other residents were identified as having the same deficient practice. **Measure in place / Systematic Changes to ensure that same practice does not recur:**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HEALTHCARE CENTER OF OAKLAND	2919 FRUITVALE AVE OAKLAND, CA 94602

(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 309	Continued From page 10 to take more medications, but she was not given an option when she was experiencing pain during the treatment. During an interview on 10/15/14 at 4:00 p.m., Director of Staff Development/Infection Control Coordinator (DSD/ICC) stated that before treatment such as dressing change for pressure ulcer, the nurse needs to give pain medication. If the resident refused pre-medication before treatment and was experiencing pain during treatment, the nurse needs to stop, assess and offer pain medication. Then continue the treatment/dressing change in about half an hour to wait for pain medication to take effect. In an interview and concurrent record review on 10/15/14 at 4:45 p.m., LVN 1 stated he was not aware if Resident 6 received pain medication before he performed the treatment that morning or if there is an order for pain medication. He said the medication nurse would provide the pain medication prior to treatment if there is an order. He stated that during treatment, Resident 6 was having pain but he stopped and gave her a break. While reviewing Resident 6 ' s medical record, LVN 1 stated that the resident has Fentanyl patch for pain management and Dilaudid 4 milligram (mg) for breakthrough pain. Review of Resident 6's electronic Medication Administration Records (eMar) showed that Dilaudid 4mg tablet was not given on 10/15/14. 2. Record review showed that Resident 8 was re-admitted to the facility on 6/28/13 with multiple medical diagnoses that included Diabetes (disease in which the blood sugar is elevated), Hyperlipedimia (high level of fat in the blood) and urinary devices (catheter). According to the Physician's order, Resident 8 needed a blood test Hgb A1c (blood test that reflects the average blood sugar level in past two	F 309	Licensed staff were in-serviced by DSD on the policy and procedure for the care and documentation of a supra pubic catheter, lab orders and pain evaluations during wound treatments by 11/11/2014 DON will observe 2 wound care treatment weekly to ensure pain is evaluated during the treatment procedure. LN will review catheter and lab order during the monthly recap and report findings to the Director of Nursing for further follow up. Medical records will conduct weekly audits of lab orders and report findings to the Director of Nursing for further follow up. **Monitoring to ensure solutions are sustained:** Don/ or designee will report findings Quality Assurance committee quarterly for review and further recommendation	

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F 309	Continued From page 11 to three months, BMP (Basic metabolic panel - blood tests that measure certain nutrients and electrolytes essential for basic body functions as well as sugar level and health of the kidneys), ALT (Alanine Aminotransferece - blood test that could detect damage to the liver), CBC (complete blood count) on 9/17/13, then every three months. Another Physician's order was sent to the facility via faxed dated 8/11/14 showed that "Laboratory at SNF tomorrow: CBC with diff, BMP. Diagnosis - Gross hematuria" (blood in the urine that can be seen by the naked eye). The physician's order was not noted by a nurse and it was filed in Resident 8's chart. In an interview and concurrent interview on 10/14/14 at 8:20 a.m., Acting Director of Nursing (ADON) stated that Resident 8's suprapubic catheter (a tube that drains urine from the bladder through the abdominal wall) gets changed at CEI (Center for Elders Independence is a day care center). When asked when the last time the suprapubic catheter was changed, ADON stated she did not know when it was last changed. She would find out if it was getting changed regularly and when it was last changed. When asked about the labs that were ordered for Resident 8, ADON stated that she thought lab work was done at CEI as well and she would call to find out. ADON verified that no these lab results were on Resident 8 records and no information to show if these tests were done or not. In an interview on 10/14/14 at 9:30 a.m., ADON stated that CEI was changing the suprapubic catheter every 6 weeks but they were not communicating with the facility that was being done. ADON confirmed that the facility was supposed to do the blood tests. During a telephone interview on 10/16/14 at 2:10	F 309		

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F 309	Continued From page 12 p.m., CEI's Nurse practitioner (NP) stated that if there was an order for the blood test, she expects the facility would communicate with CEI. If the lab tests were done, the facility would provide the results; if the resident refused, the facility would notify the CEI so they can keep track and do an intervention. NP also stated that the blood test that was ordered on 8/11/14 was faxed to the facility and the facility was expected to do the blood draw and communicated with CEI regarding the results. NP stated that since the diagnosis for the blood test was gross hematuria, we would like to know what was going on with Resident 8, and would like know the reason and what needs to be done to treat the problem.	F 309	**F 323 – Free of Accident Hazards/Supervision/Devices** **Corrective Action for those found to be affected** Residents 20's wheelchair arm rests were replaced. Resident 7's Toilet seat set was replaced.	
F 323 SS=B	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make sure 1) that Resident 20's wheelchair armrest had no cracked and rough surfaces and 2) the toilet seat in the Resident 7's restroom having no rough and cracked surfaces. This failure could potentially cause residents' skin tears from rough and cracked toilet seat and wheelchair armrests.	F 323	**Identification of other residents having the potential to be affected and corrective action** Other Residents have the potential to be affected. Administrator and Maintenance supervisor will conduct facility rounds on 11/11/2014 and any deficient area will be corrected. **Measure in place / Systematic Changes to ensure that same practice does not recur:**	11/11/14

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F 323	Continued From page 13 Findings: On 10/13/14 at 8:15 a.m., as observed with DSD (Director of Staff Development) during an initial tour, the following conditions were noted: (The DSD also noted and agreed with the observations) 1. Resident 20's both wheelchair armrests had cracked and rough surfaces. 2. Resident Room 7's toilet seat had scratched and rough surfaces. On 10/16/14 at 8:55 a.m., as observed, Resident 20's both wheelchair armrests had cracked and rough surfaces as seen during initial tour on 10/13/14.	F 323	Staffs were in-serviced by DSD on utilizing maintenance log to track facility repairs 11/11/2014. Maintenance department was in-serviced by DSD regarding completion of repair timely and tracking on 11/11/2014. Maintenance will check logs twice daily. **Monitoring to ensure solutions are sustained:** Administrator/or designee will check maintenance log and over all maintenance of the facility through routine inspections with maintenance department on a weekly basis. Results will be reported to the Quality Assurance Committee for follow up and recommendation	11/20/14
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	**F329- Drug Regiment is Free from Unnecessary Drugs** **Corrective Action for those found to be affected:** Resident 10 target behaviors were identified and updated in the resident's plan of care. Physician and IDT team evaluated resident 10 to determine the need for continued utilization of Risperdal.	

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F 329	Continued From page 14 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to have indications of target behaviors and identify behaviors that were danger to resident or others for one (Resident 10) out of 18 sampled residents. This failure resulted in putting resident on Risperdal (anti-psychotic medication) without identifying target behaviors for monitoring any adjustment needs of Risperdal dosages. Findings: Review of Resident 10's discharge summary from previous facility, discharge date: 7/22/14, Resident 10's medications included "Risperdal 0.5 mg one tablet orally, three times a day for chronic schizophrenia." Review of Resident 10's Medication Administration Record (10/2014) showed that Resident 10 was admitted on 7/22/14 to the facility with "vascular dementia with delirium, unspecified schizophrenia unspecified condition." On 10/13/14, as observed, Resident 10 was lying on her bed and greeting to surveyor pleasantly without any agitation. On 10/15/14 at 11:37 a.m., review of Resident	F 329	**Identification of other residents having the potential to be affected** Resident with order for anti psychotic medications has the potential to be affected. IDT will review these residents to ensure there is target behavior for the use of anti psychotic medications completed by 11/11/2014 **Measure in place / Systematic Changes to ensure that same practice does not recur:** IDT will review residents on psychotropic medications upon admission, quarterly, and as needed to ensure there is a target behavior for the use of the psychotropic medications. Pharmacy consultant will review residents on psychotropic medications during the monthly drug regimen review to ensure there is a target behavior for the use of psychotropic medications and report findings to the DON for follow up. Medical records will complete daily audit of the residents with new order of psychotropic medications to ensure there is a target behavior for the use of psychotropic medications and report findings to the DON for follow up.	

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F 329	Continued From page 15 10's paper medical record (physician progress notes dated 8/3/14, 8/19/14, 8/26/14, 9/2/14, 9/6/14, 9/7/14, 9/10/14, 9/16/14, 9/22/14, 9/27/14, 9/28/14, 9/30/14, 10/7/14, 10/11/14 and 10/12/14) with ADON showed that there was no indication of target behavior or behavior that was dangerous to Resident 10 or others for nursing staff to monitor when Resident 10 had a physician order dated 9/20/14 to "start 0.5 Risperidal two times a day related to unspecified schizophrenia unspecified condition until 12/19/14, 11:59 p.m. continue for 90 days, notify physician at the end of 90 days if he wants to continue." ADON said that she would review in electronic medical record to see if there were documented target behaviors for monitoring when Resident 10 was on Risperidal. On 10/15/14 at 3:05 p.m., ADON said that she already contacted Physician 2 who wanted to keep Risperdal on Resident 10. Surveyor verified with ADON that in electronic and paper medical records, there was no indication of target behavior for monitoring or any behavior dangerous to Resident 10 or others when Resident 10 was on Risperdal. ADON said that she would start to document that the monitoring target behaviors would be "yelling, cursing and calling police" for Resident 10 who was on Risperdal. On 10/16/14 at 7:47 a.m., Resident 10 yelled from her room. Surveyor greeted with Resident 10 who pleasantly said that she wanted water. Surveyor notified Resident 10's need to LVN 2. In a staff interview on 10/16/14 at 8 a.m., LVN 2 showed that she provided manufacturer's prepared thickened liquid to Resident 10. LVN 2	F 329	**Monitoring to ensure solutions are sustained:** DON/ or designee will report findings the Quality assurance committee Quarterly for review and further recommendations.	

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F 329	Continued From page 16 said that Resident 10 "was not aggressive, one or twice yelling occasionally. She got some bad time sometimes." In a staff interview on 10/16/14 at 8:10 a.m., SS reviewed Resident 10's medical record and said that Resident 10 had no behavioral issue since she was admitted on 7/22/14. SS said that she and Clinical Psychologist were involved in attending monthly psychotropic medication meetings to review residents' psychotropic medications and their behaviors. In a staff interview on 10/16/14 at 10:22 a.m., Physician 2 (Medical Director) said that Resident 10 had chronic schizophrenia, and he said, "we would like to evaluate Resident 10 first before stopping Risperdal." Physician 2 said that Resident 10 was calling out, yelling out, and grabbing people.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 17 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain free of medication error rates of five percent or greater. This failure potentially put residents at risk of sustaining complications from medication errors. Findings: On 10/14/14 from 7:52 a.m. to 9:26 a.m., medication pass observation was carried, in which there were four medication errors out of 34 medication opportunities. The medication error percent was 11.7647 that were more than five percent. The four medication errors were as follows: 1)Resident 5's 20 mg Lasix was on hold as opposed to physician order; 2) Resident 5's 50 mcg Fentanyl Patch was not given on 10/14/14 due to out of the medication supply; 3) Resident 19's 25 units of Lantus was given through subcutaneous injection when Resident 19's finger stick blood sugar was 107 (below 150); 4)Resident 19's nicotine patch 21mg/24 hour was not administered on 10/14/14 and 10/15/14 due to out of supply. 1. On 10/14/14 at 8:30 a.m., as observed in medication pass, LVN 3 provided Resident 5 with six different medications as ordered. The six medications were: 1) one soft gel of 250	F 332	**F332 – Free From Medication Error Rates 5% or More** **Corrective Action for those found to be affected** Residents 5 Lasix order which was held was reviewed and order was clarified with primary care physician during survey. Resident 5 Fentanyl Patch which was out-of-stock was obtained from the pharmacy and provided to the patient during the survey. Orders were clarified with physician by the ADON Residents 19 Physician was notified that Lantus which was provided to resident when blood sugars were below 150. Lantus order was clarified. Physician was notified that nicotine patch was out of stock for Resident 19. Order was clarified. Patch was purchased and provided at time of survey **Identification of other residents having the potential to be affected and corrective action** Residents with hold parameter order for Lantus have the potential to be affected. ADON will review the residents with order for Lantus and clarify the order as needed. Residents with order for Lasix have the potential to be affected. ADON	11/01/14

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F 332	Continued From page 18 Docusate Sodium; 2) one tablet of multi-vitamin with minerals; 3) one tablet of Carbi-Levo 25/250 mg; 4) one Gabapentin 100 mg; 5) one tablet of 200 mg carbamazepine; 6) Spiriva with handihaler. On 10/14/14 at 11:30 a.m., review of Resident 5's electronic physician orders and medication administration record showed that Resident 5 did not receive 20 mg Lasix which was ordered by a physician on 9/8/13. In a staff interview on 10/14/14 at 12:25 p.m., LVN 3 said that she did not give 20 mg Lasix to Resident 5 because his blood pressure was low which was 104/84. She said that she did not give Lasix when Resident 5's systolic blood pressure was lower than 110. LVN 3 reviewed Lasix's physician order dated 9/8/13 again that showed no blood pressure parameter to hold Lasix. LVN 3 said that she did not notify Physician 1 yet about her holding on Lasix at 9 a.m.. LVN 3 said that she would call Physician 1 that she held the Lasix. In a phone staff interview on 10/14/14 at 2:44 p.m., Physician 1 said that with Resident 5's blood pressure 104/83, pulse 82, Resident 5's 20 mg Lasix should not have been on hold even if Resident 5's systolic blood pressure was less than 120. Physician 1 said that holding Lasix could increase the problems of Resident 5's congestive heart failure (CHF). Physician 1 said that Lasix was not important in altitude of Metoprolol and Norvasc to affect blood pressure. Physician 1 said that he would contact LVN 3 about the update of his order including Lasix. Review of Resident 5's electronic medication	F 332	reviewed the charts of these residents and did not find any other residents affected by the same deficient practice. Residents with medications that are out of stock have the potential to be affected. LN completed a medication cart audit to check availability of the medications and no other residents were affected by the same deficient practice. **Measure in place / Systematic Changes to ensure that same practice does not recur:** In-services on medication administration with emphasis on following the hold parameters for Lantus, and ensuring availability of medications were provided to licensed nurses by the DON by 11/11/2014. DSD will observe LN on medication administration during orientation, annually and as needed to ensure compliance with medication administration. DON will observe 3 LN monthly on medication administration and provide 1:1 training on any identified concerns. **Monitoring to ensure solutions are sustained:** DON/ or designee will report findings to Quality Assurance committee quarterly for review and further recommendations.	

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F 332	Continued From page 19 administration records from 6/2014 to 10/14/14 showed that Resident 5 did not receive daily dose of 20 mg Lasix on 6/6/14, 6/7/14, 7/9/14, 7/15/14, 7/19/14, 7/30/14, 8/14/14, 9/1/14, 10/6/14 and 10/14/14. In a phone staff interview on 10/15/14 at 11:57 a.m., Pharm (Pharmacist consultant) said that in his data storage profile, Resident 5's diagnoses included pulmonary hypertension and heart failure. On 10/15/14 at 4:30 p.m., ADON said that she already verified with Physician 1 to change the order of Lasix into "Lasix 20 mg, give one tablet by mouth one time a day related to unspecified essential hypertension. Per physician order, Lasix has no parameter for blood pressure. Do not hold Lasix." In a staff interview and record review on 10/16/14 at 9:20 a.m., review of Resident 5's electronic medication administration record copies with MR from June 2014 to October, 2014 showed the following conditions on daily dose of Lasix not given: * no blood pressure was documented in terms of no Lasix given at 9 a.m. on 6/6/14. * blood pressure was 100/74, pulse 68, but Lasix was on hold at 9 a.m. on 6/7/14 at 9 a.m. * no blood pressure was documented in terms of no Lasix given at 9 a.m. on 7/19/14. * blood pressure was 102/72, but daily dose of Lasix was on hold at 9 a.m. on 8/14/14. * blood pressure was 104/67, but daily dose of Lasix was on hold at 9 a.m. on 9/1/14 * blood pressure was 103/64, pulse 67, but daily dose of Lasix was on hold at 9 a.m. on 10/6/14.	F 332		

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F 332	Continued From page 20 2. On 10/14/14 at 8:30 a.m., as observed in medication pass, LVN 3 provided Resident 5 with six different medications as ordered. The six medications were: 1) one softgel of 250 Docusate Sodium; 2) one tablet of multi-vitamin with minerals; 3) one tablet of Carbi-Levo 25/250 mg; 4) one Gabapentin 100 mg; 5) one tablet of 200 mg carbamazepine; 6) Spiriva with handihaler. On 10/14/14 at 11:30 a.m., review of Resident 5's electronic physician orders and medication administration record showed that Resident 5 did not receive 50 mcg Fentanyl Patch which was ordered by a physician on 9/7/13 to be applied every 72 hours. The previous application of Fentanyl Patch was 10/11/14 at 9 a.m. which had already been 72 hours during the above medication pass time. In a staff interview on 10/14/14 at 12:25 p.m., for 50 mcg Fentanyl Patch, LVN 3 said that Resident 5's Fentanyl Patch was out of supply, she could not get hold of Physician 1 to refill Fentanyl Patches. The physician order for 50 mcg Fentanyl Patch every 72 hours was still valid and current, so Resident 5 missed the dose of 50 mcg Fentanyl Patch at due time. On 10/15/14 at 15:10 p.m., review of Resident 5's electronic medication administration record (retrieved and printed on 10/15/14 at 4:07 p.m.) showed that Resident 5 missed 50 mcg Fentanyl Patch on 10/14/14 and 10/15/14. The last dose was received on 10/11/14 at 9 a.m., which already passed 72 hours of timeframe for the frequency of applying Fentanyl Patch according to physician order dated 9/7/13.	F 332		

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F 332	Continued From page 21 In a staff interview on 10/16/14 at 10:22 a.m., Physician 2 (Medical Director) said that it was a medication error when Resident 5's Fentanyl Patch already lasted and passed 72 hours without administering a new one. He said that the physicians already coordinated and would work for each other physicians if some physicians were driving or in hospitals not available to answer nurses' calls, such as refilling Fentanyl patches. He said that there was a list of alternative physicians available at nurses' stations to support and answer nurses' calls. On 10/17/14 at 7:20 a.m., ADON showed a list of physicians 2014 at nurse station near medication carts #2 and #3. ADON said that a list of physicians available for nurses to call if resident's primary physician was not available. 3. On 10/14/14 at 9:13 a.m., as observed during medication pass, LVN 2 administered 25 units of Lantus to Resident 19's left abdomen subcutaneously when his blood sugar was 107. On 10/14/14 at 11:45 a.m., review of Resident 19's electronic physician orders showed that 25 units of Lantus were ordered by a physician on 10/1/14. It was given through subcutaneous injection before breakfast daily for Diabetes Mellitus, but it needed to be on hold if finger stick blood sugar was less than 150. Resident 19 received 25 units of Lantus in this morning before breakfast even when finger stick blood sugar was below 150. In a staff interview on 10/14/13 at 12:13 p.m., LVN 2 acknowledged that she gave 25 units of Lantus through subcutaneous injection to	F 332		

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F 332	Continued From page 22 Resident 19 when his finger stick blood sugar was only 107 at 9:13 a.m. before breakfast. Review of Resident 19's electronic medical administration record in a computer notebook on Station 3 Medication Cart with LVN 2 showed that the finger stick blood sugar parameter to hold 25 units of Lantus was hidden inside "more" word that needed LVN 2 to click on. After LVN 2 clicked the "more" word, the parameter showed up to hold 25 units of Lantus if finger stick blood sugar was less than 150. LVN 2 also reviewed Resident 19's paper medical record that showed current physician order with start date as 10/1/14 to hold 25 units of Lantus if finger stick blood sugar was less than 150. LVN 2 acknowledged that Resident 19 should not have been given 25 units of Lantus when finger stick blood sugar was less than 150. Review of Resident 19's electronic medication record for 10/2014 showed that Resident 19 had received nine daily doses of 25-unit Lantus out of 14 days when his finger stick blood sugar readings were from 85 to 145, which were below 150. In a phone staff interview on 10/15/14 at 11:57 a.m., Pharm said that the duration of Lantus lasted 24 hours. According to Lexicomp (updated 10/28/14), Lantus is long-acting insulin that is used to lower blood sugar in patients with high blood sugar (diabetes). The medication duration is generally 24 hours or longer. 4. During a medication pass observation on 10/14/14 at 9:13 a.m., LVN 2 said that Resident 19's nicotine patch was out of supply. The physician order for daily Nicotine patch with start	F 332		

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F 332	Continued From page 23 date on 10/1/14 was still valid and current. Resident 19 missed the dose of Nicotine patch at due time. On 10/15/14 3 p.m., review of Resident 19's electronic medication administration record for October, 2014 (retrieved and printed on 10/15/14 at 2:54 p.m.) showed that Resident 19 missed daily dose of Nicotine Patch on 10/14/14 and 10/15/14. In a resident interview on 10/16/14 at 4:25 p.m., Resident 19 said that he did not smoke or drink anymore due to COPD (chronic obstructive pulmonary disease). He needed the prescribed Nicotine Patch for smoking cessation. He said that he did not get daily Nicotine Patch on 10/14/14 and 10/15/14.	F 332	**F371 Food Procedure, Store/Prepare/Serve - Sanitary** **Corrective Action for those found to be affected** The ground beef and chicken legs that were identified in the refrigerator as having been expired were thrown out during survey. The preferred fruit which was inappropriately stored below thawing meat and the expired dairy product were also thrown away during survey.	11/12/14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure to store meat under sanitary conditions. In the walk-in refrigerator, there were ground beef and chicken	F 371	**Identification of other residents having the potential to be affected and corrective action** All residents that eat meals from the kitchen have the potential to be affected. In-Service on the policy and procure of storing and disposal of expired foods provided to dietary staff by 11/11/2014 **Measure in place / Systematic Changes to ensure that same practice does not recur:** Dietary manager/ or designee will complete daily audits to ensure expired foods are disposed of at time of expiration and that food is properly stored on the correct side and shelves in the refrigerator.	

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F 371	Continued From page 24 legs sitting in hotel pans, that already passed their thawing hold date. In the reach-in refrigerator, there was an expired dairy product and preferred fruit stored inappropriately. This failure had the potential to cause food-borne illness and cross contamination. Findings: Based on observation and concurrent interview on 10/13/14 from 7:50 a.m. to 8:20 a.m., in the kitchen's reach refrigerator, there was a 32 ounces yogurt with expiration date of 10/06/14. The Cook stated that yogurt should not be there and should be thrown away. A four inches deep full size hotel pan with prepared fruit in it was sitting at the bottom of the refrigerator. The Cook stated that pan should be on this side of the refrigerator (she was pointing to the right side) because the condiments and deli meat product were on the shelf that was directly above the pan. In the walk-in refrigerator, at the bottom shelf there was a four inches deep hotel pan with half roll of ground beef with date of 10/05/14. Dietary Aide (DA) stated that should have been used the following day after it was pulled from the freezer. The meat should only be in the walk-in refrigerator for one day. Another four inches deep hotel pan with chicken legs and thighs with date of 10/10/14 was also sitting at the bottom shelf. The DA stated the menu for tomorrow (10/14) needed chicken. The DA checked the menu and stated that the menu needed chicken breast. DA confirmed with the Cook that they needed chicken breast, not the chicken legs and thighs. These chicken legs and thighs had been on the shelf since 10/10. DA stated that the other cook pulled the "wrong chicken" from the freezer. The Cook and the DA confirmed that meat had to be used the following	F 371	**Monitoring to ensure solutions are sustained:** Administrator/Designee will complete random audits to ensure compliance. Dietary manager will report findings to the Quality Assurance committee for review and recommendations	

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F 371	Continued From page 25 day after pulled from the freezer. Review of the facility's policy and procedure titled " Food Preparation" by RD's for Healthcare, Inc. last revised on 3/13, showed that "Meat Taken From Freezer to Thaw: Roast, steaks, chops, poultry, fish, and ground meat. Maximum Refrigeration Time Once Meat Has Thawed is 2 days". For dairy products such as "Cream, yogurt, cottage cheese, and cream cheese, sour cream is follow the expiration date or 7 days after opening, whichever comes first."	F 371	**F441 – Infection Control, Prevent Spread, Linens** **Corrective Action for those found to be affected** The Advair disk which did not contain a residents name was disposed of during survey. The replacement disk was reordered for the identified resident. LVN hired 6/2/14, LVN hired 4/19/14, Receptionist hired 8/6/14, CNA hired 5/14/14, and CNA hired 9/30/14 were offered and/or given HBV vaccination. All were screened for TB and documentation was placed in their personnel file by 11/11/2014 **Identification of other residents having the potential to be affected and corrective action** Residents that have order for inhalers have the potential to be affected. Medication cart audit was completed by LN and no other resident was affected by the same deficient practice. Staff hired has the potential to be affected. DSD completed employee file audit for TB and Hepatitis-B. TB tests, chest x-rays and Hepatitis B vaccine were offered and completed for the identified employees.	11/11/14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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F 441	Continued From page 26 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to: 1. maintain a resident identification information on the medication Advair 250/50 in one (Station 3's medication cart) out of three medication carts. This failure could potentially cause other residents to use the same diskus because it had no specific resident's name on it. 2. screen and/or provide 5 out of 6 staff members with the appropriate test and immunization to help prevent and/or spread communicable diseases. This failure had the potential to threaten all residents and staff members with preventable spread of communicable diseases. Findings: 1. On 10/14/14 at 12:43 p.m., as observed with LVN 2 to Station 3 medication cart, there were three Advair diskus. Two out of the three diskus were individually stored in its manufacturer's box with individual resident's name on. One out of the	F 441	**Measure in place / Systematic Changes to ensure that same practice does not recur:** Licensed staff was in-serviced by the DSD by 11/11/2014 regarding placing the disk back in the labeled resident's box after use. If the box is unavailable licensed nursing staff will place in a bag that is labeled with resident's information. Facility hired a DSD to maintain employee files. In-service provided to hiring managers by the Administrator regarding pre-employment and employment process regarding TB and HBV. Administrator/ or designee will review and sign off on new hire packets to ensure all documents and trainings have been completed. **Monitoring to ensure solutions are sustained:** The Administrator will routinely review all new hire packets. Findings will be reviewed at Quality Assurance Committee quarterly for follow up and recommendations.	

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F 441	Continued From page 27 three diskus had no box, and the diskus had no resident's name on it. In a phone staff interview on 10/15/14 at 12:26 p.m., Pharm said that Advair diskus could be used with its mouthpiece or with a spacer. When a resident used Advair diskus's mouthpiece, he or she would put his or her mouth directly to the mouthpiece for taking the medication. 2. During an interview and concurrent employee file review on 10/17/14 from 9:30 a.m. to 11:15 a.m., Director of Staff Development/Infection Control Coordinator (DSD/ICC), while in the presence of Quality Assurance Nurse Consultant (QANC), and Administrator (ADM), verified and confirmed that four out of six staff members were not offered or given TST (Tuberculin Skin Test), which used for screening Tuberculosis (serious bacterial infectious disease that mainly affects the lungs and are spread from one person to another through tiny droplets released into the air via coughs and sneezes.) Also, five out of six staff members were not given options to receive and/or decline an immunization for Hepatitis B (swelling of the liver due to infection caused by the hepatitis B virus (HBV), the virus can be spread through contact with the blood or body fluids of a person who has the virus.) List of employee files reviewed: 1. Licensed Vocational Nurse (LVN), she was hired on 6/2/14. Records showed that no TST screening was performed and was not offered/given Hepatitis B vaccine (HBV). 2. Licensed Vocational Nurse (LVN), she was hired on 4/19/14. Records showed that no TST screening was performed and was not	F 441		

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F 441	Continued From page 28 offered/given HBV. 3. Receptionist was hired on 8/6/14, showed no TST screening was performed and was not offered/given HBV. During the interview, DSD/ICC stated he was a receptionist and hardly did anything for him because he only worked part-time on the weekend. 4. Certified Nursing Assistant (CNA) was hired on 5/14/14, showed that no TST was performed and was not offered/given HBV. 5. Certified Nursing Assistant (CNA) was hired on 9/30/14, showed that he was not offered/given HBV. According to Centers for Disease Control and Prevention (CDC), titled "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings, 2005, pages 3 and 10. Healthcare Workers "HCWs refer to all paid and unpaid persons working in a health-care settings who have potential for exposure to M.tuberculosis through air space shared with persons with infectious TB disease. Part time, temporary, contract, and full-time HCWs should be included in TB screening programs." CDC's guidelines showed that "All HCWs should receive baseline TB screening upon hire, using two-step TST or a single BAMT to test for infection with M.tuberculosis." According to "The Occupational Safety and Health Administration (OSHA) require that hepatitis B vaccine be offered to healthcare personnel (HCP) who have a reasonable expectation of being exposed to blood and bodily fluids on the job." [http://www.immunize.org/catg.d/p2109.pdf]	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		

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F 514	Continued From page 29 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to: 1. include diagnoses CHF (congestive heart failure) and pulmonary hypertension in Resident 5's medical record. This failure resulted in that LVN 3 did not give Lasix to the resident due to lacking of information about the resident having CHF and pulmonary hypertension. 2. maintain sufficient data to show if Resident 5's blood pressure was assessed before medications (Metoprolol and Norvasc) were given to the resident. This failure resulted in that there was no evidence to show what the Resident 5's blood pressure was and if Resident 5 received the prescribed medications. Findings: 1. In a staff interview on 10/14/14 at 12:25 p.m.,	F 514	**F514 – Records-Complete/Accurate/Accessible** **Corrective Action for those found to be affected** Residents 5's medical record was updated to include CHF and pulmonary hypertension. Resident 5's blood pressure is being documented in the clinical record to review prior to provide blood pressure medications. **Identification of other residents having the potential to be affected and corrective action** Other residents have the potential to be affected. Medical records will complete an in house chart audit to ensure resident's record contains the updated diagnosis. Medical Records designee will complete a medication administration record audit and any resident affected by the same deficient practice will be corrected by 11/12/2014 **Measure in place / Systematic Changes to ensure that same practice does not recur:** DON will in service LN on the accuracy and completeness of clinical records with emphasis on the documentation of Blood pressure on the Medication administration record by 11/12/2014. Medical record designee will audit the Medication administration record weekly for omissions and or similar errors. Findings will be given to the DON for follow up.	11/12/14

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F 514	Continued From page 30 LVN 3 stated that she did not give Lasix 20 mg to Resident 5 during the medication pass on 10/14/14 at 8:30 a.m. because Resident 5's blood pressure was low 104/84. She said that she held blood pressure medications (Lasix, Metoprolol and Norvasc) when Resident 5's systolic blood pressure was below 110. In a phone staff interview on 10/14/14 at 2:44 p.m., Physician 1 stated that with Resident 5's blood pressure 104/84, pulse 82, Resident 5's Lasix 20 mg should not have been on hold even if Resident 5's systolic blood pressure was less than 120. Physician 1 stated that holding Lasix could increase the problems of Resident 5's congestive heart failure (CHF). Physician 1 said that Lasix was not important in altitude of Metoprolol and Norvasc to affect blood pressure. Physician 1 said that he would contact LVN 3 about the update of his order including Lasix. Review of Resident 5's electronic medication administration records from 6/2014 to 10/14/14 showed that Resident 5 did not receive daily dose of Lasix 20 mg on 6/6/14, 6/7/14, 7/9/14, 7/15/14, 7/19/14, 7/30/14, 8/14/14, 9/1/14, 10/6/14 and 10/14/14. In a phone staff interview on 10/15/14 at 11:57 p.m., Pharm (Pharmacist) said that in his data storage profile, Resident 5's diagnoses included pulmonary hypertension and heart failure. On 10/17/14 at 7:26 a.m., ADON stated that she verified with Physician 1 today that Resident 5 had CHF and pulmonary hypertension. ADON stated that she added these two diagnoses into Resident 5's medical record. ADON told the surveyor that Physician 1 stated he already added	F 514	MDS nurse will review resident's clinical record for medical diagnosis during the initial, quarterly, annual MDS assessment. **Monitoring to ensure solutions are sustained:** DON/ or designee will report findings to the Quality Assurance committee quarterly for review and further recommendations.	

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F 514	Continued From page 31 these two diagnoses before, but the electronic medical record program missed the information. In a staff interview on 10/17/14 at 8:17 a.m., LVN 3 stated that Resident 5's medical record did not show that Resident 5 had diagnoses of CHF and pulmonary hypertension. LVN 3 stated that she held Resident 5's Lasix because Resident 5's systolic blood pressure was less than 110. 2. On 10/16/14 at 9:20 a.m., MR (Medical Record staff) stated that she already reviewed Resident 5's electronic medical record (eMAR and nurses notes) and identified the followings: a. On 6/6/14, Resident 5 did not receive 9 a.m. dose of Lasix, Metoprolol and Norvasc. There was no documentation on the MAR (Medication Administration Record) to show that Resident 5's blood pressure was assessed and the reasons why the resident did not receive the medications. b. On 6/12/14, Resident 5 received 9 a.m. dose of Metoprolol and Norvasc, but no documentation showed on the MAR that the resident's blood pressure was assessed. According to the physician orders, dated 9/7/13, nurses needed to check blood pressure before giving Metoprolol and Norvasc.	F 514		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.	F 518		

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F 518	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate training for 3 out of eight staff members in disaster preparedness, to ensure a continuing state of readiness in an event of an emergency. This failure had the potential to threaten the safety and well-being of all the residents, in the event of an emergency. Findings: During an observation and concurrent interview on 10/15/14 at 11:00 a.m., Certified Nurse Assistant (CNA) 1 was asked the location and instructions to shut off water supply valve during an emergency. CNA 1 identified emergency water shut-off valve and stated that she did not aware on the procedure to shut off the water supply. When asked to identify the location of emergency gas shut-off valve, CNA walked over to the front of the generator. She stated that she did not know how to shut it off. In observation and concurrent interview on 10/15 at 11:10 a.m., Laundry aide (LA) was asked to locate and to give instructions to shut off the gas shut-off valve. LA walked to the front of the generator and pointed that was the gas shut-off. LA stated that she did not know how to shut off the valve. During an observation and concurrent interview on 10/15/14 at 10/15/14 a.m., Social Services (SS) was asked to show the location and instructions to shut off water supply during an emergency. SS walked out of the front door and stated it was outside near the front of the building. SS walked over to a pipe that was extending out from the wall, SS pointed and stated "That's the water shut off valve." The pipe had a label on top	F 518	**F518 Train All Staff-Emergency Procedures/Drills** **Corrective Action for those found to be affected** CNA 1 was in-serviced DSD on the procedure to shut off the water in an emergency and how to shut off the gas. LA was in-serviced by the DSD on how to shut off the valve for the gas in an emergency. SS was in-serviced by the DSD on the location and procedure of shutting off the water and gas during an emergency by 11/12/2014 **Identification of other residents having the potential to be affected and corrective action** No residents were listed as having been affected in the statement of deficiencies. Director of Staff Development will in-service staff in disaster preparedness to ensure a continuing state of readiness in the event of an emergency by 11/ 12/ 2014 **Measure in place / Systematic Changes to ensure that same practice does not recur:** Director of Staff Development (DSD) will in-service staff on facility's disaster preparedness emphasizing where the gas and water shut off	11/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056280	A. BUILDING _____ B. WING _____	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 518	Continued From page 33 showing "Automatic sprinkler shut-off valve". Review of the facility's emergency procedure titled "Windsor Healthcare Center of Oakland Emergency Procedure" showed "Shut Off Locations Water-Front of the Building" "Gas-Side of the building (Fence Side)." The procedure did not include the process on shutting off the water and gas valves. According to the Federal Emergency Management Agency (FEMA), "Natural gas leaks and explosions are responsible for significant number of fires following disasters. It is vital that all household members know how to shut off natural gas. Water quickly becomes a precious resource following many disasters. Cracked lines may pollute the water supply to your house. It is wise to shut-off your water supply until you hear form authorities that it is safe for drinking". [http://www.ready.gov/utility-shut-safety]	F 518	valves are located and how to turn them off. The Administrator, Director of Nursing and or Director of Staff Development will validate staff disaster preparedness by selecting random staff and asking questions about where the gas and water shut off valves are located and how to turn them off. Any negative findings will be discussed with the staff at the time of the occurrence for immediate re-education and then presented to DNS/DSD for reviewing and trending. The DSD or designee will conduct quarterly emergency / disaster preparedness drills emphasizing on validating staff competency of understanding where the gas and water shut off valves are located and how to turn them off. Findings will be reported to the Administrator with appropriate corrective actions. **Monitoring to ensure solutions are sustained:** DSD will provide results of findings to the Quality Assurance Committee quarterly for further recommendations and follow up.	