Reviewed and accepted on 2/28/12 Isabella Adams

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

PRINTED: 02/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056056	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNVIEW CONVALESCENT HOSPITAL	126 N. SAN GABRIEL BLVD. SAN GABRIEL, CA 91775

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a RECERTIFICATION survey. Representing the Department of Public Health: 30258 28074 07598 Total Resident Population: 61 Total Resident Sample: 15 Highest Scope and Severity: E	F 000	This Plan of Correction Constitutes my written credible allegation for the Deficiencies noted.	
F 272 SS=G	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	January 19,2012 F 272 483.20(b) (1) Comprehensive Assessments Resident #11, MDS, Section J under Shortness of Breath. Per RAI Manual Chapter 2, Section J1100, Page J-21 states to mark this section if no shortness of breath is noted. Medical records indicate no shortness of breath for resident #11. January 19,2012 Resident identified with orders for Oxygen has been reviewed for shortness of breath. Utilizing the physician orders through auditing system will monitor those residents who may be affected by this practice. January 19,2012 Resident #11: On January 10, 2012 This MDS was electronically transmitted and accepted by Quality Improvement and Evaluation Service. Section V0200 CAA (care area assessment) location and date of CAA information was completed 12/28/2011. Location and date of the	

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

Dipak B. Desai — Administrator — 2-21-12

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FERNVIEW CONVALESCENT HOSPITAL	125 N. SAN GABRIEL BLVD. SAN GABRIEL, CA 91775

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F 272	Continued From page 1 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the comprehensive assessment identified and included that 1 of 15 sampled residents (Resident 11) was on continuous oxygen use, and that the date and location of the CAA assessment information was completed and signed as required. Findings: On January 10, 2011, at 8:30 a.m., a review of the admission and discharge summary of Resident 11, indicated the resident was admitted to the facility on August 1, 2010, with diagnoses that included diabetes mellitus (high blood sugar), atony of bladder (inability to urinate properly due to a lack of muscular tone), depression and psychosis.	F 272	F272 CONTINUED FROM PAGE 1 CAA information is located under the CAA notes on page 34 of 39 in the MDS. As an example, this information is located in the chart as denoted by "See CAA Note #8 12/28/2011" AS per RAI manual page 4-6 to 4-7 , Chapter 4, it states a written documentation of the CAA findings and decision making process may appear anywhere in a residents records as an example in the CAA narrative. January 19,2012 MRD will audit MDS for monitoring system of information, documentation, signatures and dates.	

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FERNVIEW CONVALESCENT HOSPITAL	126 N. SAN GABRIEL BLVD. SAN GABRIEL, CA 91775

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F 272	Continued From page 2 A review of the annual MDS dated December 25, 2011, Section O for Special Treatments and Procedures indicated that the resident was on oxygen therapy. However, Section J for shortness of Breath (dyspnea- condition where you are experiencing shortness of breath, or breathlessness.) was not marked to indicate that the resident had shortness of breath since the resident was on continuous oxygen use. Additionally, the MDS assessment Section V for Health Conditions and Care Area Assessment (CAA) Summary indicated the following areas of concerns were triggered: Delirium, Cognitive Loss/Dementia, Visual, Communication, Urinary Incontinence and Indwelling Catheter, Mood State, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer, and Psychotropic Drug Use. However the section Location and Date of CAA Information, which indicates where to locate in the resident's record the reason the care areas were triggered was not completed. Also the MDS nurse coordinator for the CAA process and the person who completed the care plans did not sign the form as required. On January 10, 2012, at 9 a.m., an interview was conducted with MDS Coordinator 1. MDS Coordinator 1 reviewed the record of Resident 11 and stated that Section J-1100 for Shortness of breath should have been marked since the resident is on continuos oxygen use. She also stated that date of the CAA information should had been completed and signed on both spaces at the bottom of Section V.	F 272		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	F 315 483.25(d) No Catheter, Prevent Urinary Tract Infection, Restore Bladder Resident 2, 5, 10, 9 and 11 indwelling urinary	

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F 315	Continued From page 3	F 315	F 315 CONTINUED FROM PAGE 3	

assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that that an indwelling catheter was properly positioned and securely anchored to prevent pain, accidental dislodgement and to facilitate urine drainage from the bladder to prevent urinary tract infection (UTI) for five of fifteen sample residents (2, 5, 9, 10, and 11) out of 15 total residents with indwelling catheters.

Findings:

a. During the initial tour on January 4, 2012, at 9 a.m. on Station Two accompanied by the Registered Nurse, Resident 2, 5, 10 and 11, were observed with indwelling catheters that were not anchored properly. A plastic tubing was connected to a urinary collection bag that was anchored to the frame of the bed. Upon further observation, it was noted that the indwelling catheter tubes were not anchored to the resident's upper leg or abdomen to ensure proper positioning of the catheter inside the bladder for proper drainage of urine.

catheter were secured using leg strap. Care plan updated to include prevention of pain, accidental dislodgement and to facilitate urine drainage to prevent urinary tract infections. Nursing staff were in-serviced on how to position and secure indwelling catheters.

January 27, 2012
The facility will identify other resident's having the potential to be affected by using the physician orders. No other residents were identified with orders of indwelling catheter.

Policy and Procedure of care of indwelling catheter was revised to include how to anchor the urinary tubing using leg strap to prevent accidental dislodgement. Nursing staff were in-serviced on how to properly position and secure indwelling catheters. License staff will check proper use of leg strap and positioning of indwelling catheters during routine rounds.

January 27, 2012
License Nurse will identify indwelling catheters need for a leg strap. Staff Developer will report to Quality Assurance Committee the number and effectiveness of the leg straps.

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F 315	Continued From page 4	F 315		

It is recommended that all urinary catheters should be secured to the thigh for women and to the upper thigh or lower abdomen for men. Unsecured urinary catheters can lead to bleeding, trauma, pressure sores around the meatus, and bladder spasms from pressure and traction. (JoAnn Mercer Smith, Catheter Securement November 8, 2008).

During an interview with the Registered Nurse (RN) Supervisor on January 5, 2012, at 2 p.m., she stated the Foley catheter's were placed for management of Stage 3 pressure ulcers (the skin breakdown looks like a crater) and Stage 4 pressure ulcers (the pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints) and urinary retention. The RN supervisor further stated that the indwelling catheter tubes were positioned below the bladder at all times but was not sure about securing or anchoring them. She stated she would check the policy and procedure regarding the positioning of the tubing's.

The Treatment Nurse was interviewed during the treatment of the wound on January 9, 2012, at 9:15 a.m. The Treatment Nurse stated that the urinary tubing was usually placed on top of the thigh and tucked under the thigh. She further stated that the urinary collection bag was always placed below the bladder. She also stated that the facility did not have a policy and procedure on how to properly anchor the urinary tubing's in order to prevent accidental dislodgement.

A review of the undated policy and procedure

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F 315	Continued From page 5	F 315		

titled, Catheter- Care of the Indwelling Catheter, did not include the prevention of accidental dislodgement that can cause trauma to the urethra.

According to the admission record Resident 2 was admitted to the facility on October 10, 2011, with diagnoses that included debility, diabetes mellitus, pressure ulcers, Alzheimer's disease, hypertension (elevated blood pressure) and depressive disorder.

During the initial tour on January 4, 2012, at 9:30 a.m., Resident 2 had an indwelling catheter with a yellow colored fluid draining into the urinary collection bag. According to the RN, the indwelling urinary catheter was for management of a Stage III pressure sore on her sacral (a large bone at the bottom of the spine) and at the gluteal (one of the large muscles in the buttocks).

A review of the initial MDS dated October 14, 2011, indicated Resident 2, was moderately impaired with cognitive skills for daily living, was totally dependent on staff for ADL's, had two unstageable pressure sores and an indwelling catheter.

A review of the care plan titled, "Bowel and Bladder", dated October 10, 2011, did not include interventions for prevention of injury related to possible dislodgement of the indwelling urinary catheter.

According to the admission record Resident 5 was admitted to the facility on September 12, 2011, with diagnoses that included congestive heart failure (a condition where the heart can no

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longer pump enough blood to the rest of the body) and pressure ulcers. A review of the MDS dated January 5, 2012, indicated the resident had the ability to understand others, and required extensive assistance with all activities of daily living. The MDS also indicated the resident had a Stage IV pressure sore and an indwelling catheter.

According to the admission record Resident 10 was admitted to the facility was admitted to the facility on September 13, 2011, with diagnosis that included debility, gastrostomy tubes (tube inserted surgically through a small incision in the abdomen into the stomach and is used for long term nutrition and medication administration.) A review of the MDS dated December 15, 2011, indicated Resident 10 had impaired cognitive skills in daily decision making, was totally dependent on staff for all ADL's, had an indwelling catheter and a Stage 3 pressure ulcer to sacrococcyx (joint pain occurs where the sacrum vertebrae in the spine connect to the coccyx, or tail bone)

According to the admission record Resident 11 was admitted to the facility on August 1, 2010, with diagnoses that included diabetes mellitus, atony of the bladder (lack of normal muscle tone), dementia and hypertension. A review of the MDS dated December 26, 2011, indicated Resident 11 was moderately impaired in daily decision making, required extensive assistance to total dependence on staff in ADL's. The MDS also indicated that the resident had an indwelling catheter. The physician's order dated August 1, 2010, included an order to use an indwelling catheter due to a diagnosis of atony (urinary

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F 315	Continued From page 7	F 315		

bladder that does not empty, usually due to disturbance of innervation or to chronic obstruction).

A review of the care plan titled, "history of pulling out catheter" dated September 30, 2011, did not include interventions to prevent of injury related to possible dislodgement of the indwelling urinary catheter.

b. A review of the admission record on January 4, 2012 at 10 a.m., indicated Resident 9 was admitted to the facility on December 30, 2011, with diagnoses that included hypertension (increased blood pressure), depression, and heart disease.

A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated January 6, 2012, indicated that the resident was able to make herself understood and was able to understand others. The resident was totally dependent on staff for transfers and activities of daily living (ADL's) such as eating, dressing, and hygiene. The MDS also indicated that the resident had an indwelling urinary catheter (a flexible plastic tube used to drain urine from the bladder).

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F 315	Continued From page 8 During the observation of a dressing change on January 5, 2012, at 10 a.m., the resident did not have a strap/device to secure the indwelling urinary catheter from becoming dislodged from the urethra. A review of the care plan titled, "Bowel and Bladder", dated December 30, 2011, did not include interventions for prevention of injury related to possible dislodgement of the indwelling urinary catheter. During an interview, on January 10, 2012 at 10 a.m., certified nurse assistant 1(CNA 1) was asked if Resident 9 had ever had a device/strap to hold the urinary catheter in place in order to prevent it from becoming dislodged. The CNA stated she had never seen any kind of device/strap on the resident until that day. The CNA was asked if she had ever seen a device/strap to hold the urinary catheter in place on any of the residents in the facility who had indwelling urinary catheters, she stated she had not seen any type of securing device on any of the residents in the facility.	F 315		
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.	F 329	F 329 483.25(l) Drug Regimen is Free from Unnecessary Drugs Order for Dilantin level was obtained for resident 7 and was put on seventy two hour monitoring for signs and symptoms of toxicity and seizure activity. Care plan updated to include when to monitor Dilantin levels and to include subtherapeutic level. Order also obtained to	January 27, 2012

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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 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 interview and record review, the facility failed to monitor serum blood levels for the anticonvulsant Dilantin and to hold the tube feedings 1-2 hours before the administration of phenytoin (Dilantin) for one (Resident 7) of 15 sampled residents. This failure had the potential to result in toxicity, as well as the possibility of having sub-therapeutic blood levels which could result in seizure activity.

Findings:

A review of the admission information on January 4, 2012, at 1:10p.m., indicated Resident 7 was admitted to the facility on August 2, 2011, with diagnoses that included Alzheimer's (the most common type of dementia, a general term for memory loss and other intellectual abilities), seizure disorder (results from abnormal electrical activity in the brain in which the body shakes

F 329 F 329 CONTINUED FORM PAGE 9

hold tube feedings one hour before and after medication administration. Licensed staff was in-serviced on proper administration of Dilantin.

January 27, 2012

Resident with orders for Dilantin medication are identified as having the potential for this same deficient practice. All residents with Dilantin medication have routine laboratory Dilantin level order.

January 27, 2012

The Licensed staff was in-serviced to ensure to obtain physician order for routine Dilantin level for residents with Dilantin medication. Medical Records designee will review physician orders monthly of residents who are on Dilantin medication to ensure that there is routine aboratory order for Dilantin levels.

January 27, 2012

Director of Nursing or her Designee, will be responsible for monitoring corrective action and document findings in quality assurance reports which will be reviewed by the Quality Assurance Committee quarterly for effectiveness.

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FERNVIEW CONVALESCENT HOSPITAL	128 N. SAN GABRIEL BLVD. SAN GABRIEL, CA 91775

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rapidly and uncontrollably), and contractures (the chronic loss of joint motion due to structural changes in non-bony tissue).

A review of a physician's order dated August 2, 2011, indicated to administer Dilantin 300 milligrams (mg) 4ml enteral tube (tube feeding) every day at noon for convulsions.

On January 5, 2012, at 11:50 a.m., Resident 7 was observed lying in her bed asleep. The tube feeding (Fibersource) was infusing via a feeding pump at a rate of 60cc (milliliters) per hour. Dilantin was scheduled to be administered at 12 Noon.

According to Lexicomp, Phenytoin serum concentrations may be altered if taken with food. If taken with enteral nutrition, phenytoin serum concentrations may be decreased. Tube feedings decrease bioavailability; hold tube feedings 1-2 hours before and 1-2 hours after phenytoin administration.

A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated August 8, 2011, indicated the resident was rarely or never able to make herself understood or able to understand others. The resident was totally dependent on staff for activities of daily living (ADL's) such as transfers, dressing, eating, toileting, and hygiene.

A review of a laboratory report dated August 8, 2011, indicated Resident 7's Dilantin level was low 8.7 micrograms /milliliter (mcg/ml). Normal levels are 10.0 - 20.0 mcg/ml.

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A review of the untitled care plan dated October 20, 2011, which addressed the resident's seizure disorder indicated as interventions pharmacy consultant to review medications during scheduled visits for recommendations, shake well prior to giving, and monitor for seizure activity. The interventions did not include monitoring of Dilantin blood levels. Nor did it include the laboratory result of the sub-therapeutic level that was obtained on August 8, 2011.

According to Davis's Drug Guide for Nurses, phenytoin levels should be routinely monitored. Signs of phenytoin toxicity include ataxia (lack of coordination during voluntary movements), confusion, nausea, slurred speech, and dizziness.

In an interview on January 5, 2012, at 9:40 a.m. licensed vocational nurse 1 (LVN 1) stated it is important to monitor Dilantin in order to make sure the levels are appropriate. The LVN also stated if there was a resident who was receiving Dilantin but was not having the levels monitored she would call the doctor and request an order to have the resident ' s levels checked.

In an interview on January 5, 2012 at 10:20 a.m., LVN 2 stated if she had a resident who was receiving Dilantin, and blood levels of the medication were not being monitored, she would call the physician and obtain an order to monitor the blood levels. The LVN stated it was common for blood levels to be drawn every three months for residents who are taking Dilantin.

On January 5, 2012 at 10:50 a.m., in an interview,

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the director of nursing (DON) stated Dilantin levels should be monitored. The DON stated if there are no orders from a resident's physician or recommendations from the pharmacist to monitor Dilantin levels then as a nurse she would call the doctor and obtain an order to check Dilantin levels. When asked if there was an order to monitor Dilantin levels for Resident 7, the DON stated there was not. The DON was also asked if there was a re-check done following the sub-therapeutic laboratory result of Resident 7 ' s Dilantin level in August 2011. The DON stated a re-check was not done. The DON was asked if the facility had a policy regarding the administration of Dilantin, she stated the facility did not have a policy regarding administration of Dilantin.

In an interview on January 6, 2012 at 1:40 p.m., LVN 3 stated it is important to monitor for toxicity and seizures when residents are taking Dilantin. The LVN stated if too much of the medication is given it can cause toxicity and if too little of the medication is given the resident can have seizures.

After having brought it to the attention of the facility that Dilantin blood serum levels were not being monitored the physician was notified and levels were drawn. The laboratory result dated January 6, 2012, (during the annual recertification survey) indicated Dilantin level was low <2.5 mcg/ml (normal range is 10.0-20.0 mcg/ml).

According to the State Operations Manual (SOM) monitoring of serum medication concentrations for phenytoin should be done. Serum medication concentrations may help identify toxicity, but

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F 329	Continued From page 13 significant signs and symptoms of toxicity can occur even at normal or low serum concentrations.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the pharmacist consultant failed to make recommendations to the physician, and director of nursing , for the monitoring of blood serum levels of the anticonvulsant Dilantin (phenytoin) for one (Resident 7) of 15 sampled residents. This failure had the potential to result in Dilantin toxicity as well as the possibility of having sub-therapeutic blood levels which could result in seizure activity. Findings: A review of the admission information on January 4, 2012 at 1:10p.m., indicated Resident 7 was admitted to the facility on August 2, 2011. Diagnoses included Alzheimer ' s (the most common type of dementia, a general term for	F 428	483.60(c) Drug Regimen Review, Report Irregular, Act On An order for routine Dilantin serum was obtained for Resident 7. Monitoring of Dilantin blood levels including subtherapeutic result was added in the care plan. Pharmacy consultant was informed of failure to make recommendation for monitoring blood serum for Dilantin. January 21, 2012 All residents with orders for Dilantin medication are identified as having the potential for this same deficient practice. All residents with Dilantin medication have routine laboratory Dilantin level order. January 21, 2012 Medical Records Designee will audit physician orders monthly of residents who are on Dilantin medication to check for routine laboratory order for Dilantin levels. Missing routine laboratory orders will be reported to the Registered Nurse Supervisor. January 21, 2012 Director of Nursing or her Designee will be responsible for monitoring corrective action and document findings in Quality Assurance report which will be reviewed by the Committee. The Committee will offer recommendations after reviewing the findings.	

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memory loss and other intellectual abilities), seizure disorder (results from abnormal electrical activity in the brain in which the body shakes rapidly and uncontrollably), and contractures (the chronic loss of joint motion due to structural changes in non-bony tissue).

A Minimum Data Set (MDS), a standardized assessment and care screening tool , dated August 8, 2011, indicated the resident was rarely or never able to make herself understood or able to understand others. The resident was totally dependent on staff for activities of daily living (ADL ' s) such as transfers, dressing, eating, toileting, and hygiene.

A review of a physician ' s order dated August 2, 2011, indicated Dilantin 300 milligrams (mg) 4ml enteral tube (tube feeding) every day at noon for convulsions.

A review of a laboratory report dated August 8, 2011, indicated Resident 7 ' s Dilantin level was low 8.7 micrograms /milliliter (mcg/ml). Normal levels are 10.0 - 20.0 mcg/ml.

The pharmacy consultant's, Medication Regimen Review, for the months of August, September, October, November, and December 2011 were reviewed. During the five month period there were no recommendations to monitor Dilantin blood serum levels for Resident 7.

A review of the unitlied care plan dated October 20, 2011, which addressed the resident ' s seizure disorder , indicated as interventions pharmacy consultant to review medications during scheduled visits for recommendations,

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shake well prior to giving, and monitor for seizure activity. The interventions did not include monitoring of Dilantin blood levels. Nor did it include the laboratory result of the sub therapeutic level that was obtained on August 8, 2011.

According to Davis ' s Drug Guide for Nurses, phenytoin levels should be routinely monitored. Signs of phenytoin toxicity include ataxia (lack of coordination during voluntary movements), confusion, nausea, slurred speech, and dizziness.

In an interview on January 5, 2012 at 9:40 a.m. licensed vocational nurse 1 (LVN 1) stated it is important to monitor Dilantin in order to make sure the levels are appropriate. The LVN also stated if there was a resident who was receiving Dilantin but was not having the levels monitored she would call the doctor and request an order to have the resident s levels checked.

During an interview, on January 5, 2012 at 10:20 a.m., LVN 2 stated if she had a resident who was receiving Dilantin, and blood levels of the medication were not being monitored, she would call the physician and obtain an order to monitor the blood levels. The LVN stated it was common for blood levels to be drawn every three months for residents who are taking Dilantin.

On January 5, 2012 at 10:50 a.m., in an interview, the director of nursing (DON) stated Dilantin levels should be monitored. The DON stated if there are no orders from a resident 's physician or recommendations from the pharmacist to monitor Dilantin levels then as a nurse she would call the

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doctor and obtain an order to check Dilantin levels. When asked if there was an order to monitor Dilantin levels for Resident 7 the DON stated there was not. The DON was also asked if there was a re-check done following the sub-therapeutic laboratory result of Resident 7 ' s Dilantin level in August 2011. The DON stated a re-check was not done. The DON was also asked if the facility had a policy regarding the administration of Dilantin, she stated the facility did not have a policy regarding administration of Dilantin.

In an interview on January 5, 2012 at 3:30 p.m., the MDS nurse was asked if blood serum levels should be monitored for residents taking Dilantin. The nurse said " Yes, they should be monitored " . When asked why monitoring of Dilantin levels was not an intervention on Resident 7 's care plan the nurse stated " We look at pharmacy recommendations if there are no recommendations then we do not put it on the care plan " . The MDS nurse also stated if blood serum levels are drawn and the result is low/sub-therapeutic we notify the physician, ask for a re-check, and the result of the laboratory work would be added to the care plan. When asked if a re-check was requested following Resident 7 ' s sub-therapeutic level in August 2011, the nurse stated a re-check was not requested. The nurse was also asked if the sub-therapeutic level had been added to the care plan, she stated it had not.

On January 5, 2012 at 3:55 p.m., in an interview, the pharmacy consultant was asked what recommendations would be made for residents who were receiving the anti-convulsant Dilantin.

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F 428	Continued From page 17 The pharmacist stated she would recommend the monitoring of blood serum levels but that there are no guidelines regarding a time frame for when levels should be checked. During an interview on January 6, 2012 at 1:40 p.m., LVN 3 stated it is important to monitor for toxicity and seizures when residents are taking Dilantin. The LVN stated if too much of the medication is given it can cause toxicity and if too little of the medication is given the resident can have seizures.	F 428	THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN CREDIBLE ALLEGATION FOR THE DEFICIENCIES NOTED	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 13 out of 31 multiple resident bedrooms (5, 7, 9, 11, 15, 16, 17, 18, 19, 20, 21, 22, and 23) measured at least 80 square feet per resident. Findings: During the initial tour, on January 4, 2012, at 9:00 a.m., resident rooms 5, 7, 9, 11, 15, 16, 17, 18, 19, 20, 21, 22, and 23, were observed with three beds within each room. A review of a room waiver request dated January 4, 2012, indicated that the square footage of the aforementioned rooms was 217 square feet.	F 458	F 458 483.70(d) (1) (ii) Bedrooms Measure at Least 80 SQ ft/resident A request for Room Waiver was submitted January 4, 2012. January 4, 2012 Daily room rounds by staff continue to ensure rooms remain in a functional, safe environment. This observation will continue to ensure residents care and needs are met and provided for. January 4, 2012 Quality Assurance and Patient Care Plan Committee shall review quarterly findings and make recommendations.	

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F 458	Continued From page 18 (72.3 square feet per resident) which fell short of the requirement of 240 square feet for a 3 bed resident room. During interviews with residents during the group interview meeting on January 9, 2012, at 10:30 a.m., and during individual interviews, none of the residents expressed any problems regarding the size of the rooms. During the course of the survey from January 4 through 11, 2012, no problems were observed with residents being able to get out of their rooms or with staff being able to give care, provide treatments or administer medications.	F 458		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the dietary staff stored the floor freezer in an environment that was not free from the entry of pests. Findings: During an environmental tour on January 4, 2012, at 2:00 p.m., a floor freezer was observed in the basement in a storage room that had double doors opening directly outside the facility to the parking lot. Upon closer inspection of the doors, a	F 469	F 469 483.70(h) (4) maintains Effective Pest Control Program On January 4th, 2012 Plant Supervisor, immediately placed two rubber door stripping (sweep) under the doors that l ead to basement. This was completed on January 4th, 2012 These doors shall be checked periodically during rounds by Plant Supervisor and Administrator. They shall be observed for wear and tear. They shall be replaced as needed. Plant rounds can be reported to Quality Assurance Committee and Plant Supervisor for any recommendations or corrections. Completion Date: January 4th, 2012	

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gap was observed between the bottom of the doors and the floor of the room. Using a metal tape measurer, the evaluator determined the gap was one and a quarter inch high and 71 inches wide across the full width of the doors. According to Salvato's "Environmental Engineering And Sanitation" Third Edition, page 937, mice can pass through a one half inch diameter hole.

The floor freezer contained frozen vegetables and hash brown patties which were at a temperature of zero degrees Fahrenheit. The freezer was observed to be clean and in good repair. At the time of the observation, there was no evidence of a rodent infestation.

During an interview, with the dietary supervisor, on January 24, 2012, at 2:30 p.m., she stated the reason the floor freezer was placed in the basement was because there was no room upstairs in the kitchen.