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

PRINTED: 12/20/2013
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
	056430	A. BUILDING _____ B. WING _____	11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHGATE CARE CENTER	40 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an annual Recertification Survey. Representing the California Department of Public Health: Health Facilities Evaluator Nurses:29797, 28521, and 33232. The Facility census on the date of entry, 11/4/13, was 46 with no bed holds. There were 12 sampled residents and 11 un-sampled residents. There were no complaints or ERIs investigated during the survey.	F 000	Preparation and/or executive of this plan of correction does not constitue admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiences. The plan of correction is prepared and/ or executed soley because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 405.1 Section 7	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164	Administrator's Initials CP The plan of correction will serve as the facility's Credible Allegation of Compliance. The facility will maintain the residents' right to personal privacy and confidentiality of his or her personal and clinical records.	11/07/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Petrucelli | TITLE: Admin | (X6) DATE: 12/30/13

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.

1/6/14 POC accepted. Administrator notified.
Linda Petrucelli HFEA

JAN 02 2014
CDPH L&C
Santa Rosa D.O.

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F 164	Continued From page 1 contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility documentation, the facility failed to protect and uphold confidential, personal and clinical information for one of 12 sampled residents (Resident #5) and two Random Residents #18 and #19. This failure had the potential to reveal personal information of the resident to outside visitors. Findings: Observation on 11/07/2013 at 9:15 A.M. it was noted that there were two signs posted in the residents ' room in view for all to read. One sign at the head of her bed on the wall and the other on the outside of her storage closet stating how to position her and her bed. The sign stated, " Do not put the bed against the wall and the blinds. [#5] CANNOT see out and is condemned to lie in the dark. " During an interview with Management Staff G on 11/07/2013 at 9:20 regarding the signs posted in the room of #5, Management Staff G stated that the family of resident #5 wants it posted so that the blinds remain open. On 11/08/2013 at 10:40 in the room of resident #18 a sign was posted on the wall next to residents bed instructing to 'handle gently - orthopedic surgery on left arm with metal plate'. On 11/08/2013 at 1045 in the room of resident #19 there was a sign posted at the head of thier bed stating "She has a shoulder injury. Handle	F 164	The signs posted in the rooms for Residents #5, #18 and #19 were removed. The Director of Nursing made rounds to ensure no other residents were effected by this deficient practice. The facility implemented a practice of posting a sign directing staff to the nurses station in cases of special request by families or special needs regarding plan of care. No posting of signs will be done without the consent of the Administrator or Director of Nursing. All staff was inserviced by the Director of Staff Development on the implemenation of the new practice. The Director of Nursing will conduct weekly rounds to ensure the facility remains in compliance.	11/8/13 12/23/13 12/30/13

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F 164	Continued From page 2 gently".	F 164	Ongoing issues will be referred and reported during the monthly QA Committe for follow up and recommendations.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to provide activities or an ongoing program of stimuli to meet the interest and well-being for 1of 12 sampled residents when: Individualized activities were not developed for this resident which had the potential to increase depression, isolation, lethargy and preventing the resident from reaching their highest practical psychosocial well-being. Findings: During an initial tour on 11/04/13 at 9:25 A.M. resident #5 was in in bed facing the window. There was a radio by her bed that was not on nor was it plugged in. No one was interacting with the resident at this time. There was no TV in her room. At 10:00 A.M. on 11/04/13 a group activity was being conducted by staff in the dining room. The interactive activity was a quiz game where the activity leader would ask questions and the residents would answer. There were 13 residents present. Out of the 13, six were sleeping, two were awake but just sitting in their wheelchairs with no participation, one was reading a week old	F 248	The facility will provide for an ongoing program of activities to meet the interests and needs of each resident. Resident #5's activity careplan was updated to reflect an ongoing program to ensure the interests, the physical, mental and psychosocial well-being of the resident. The following changes were made to Residentx #'s careplan: Resident's ipod to remain plugged in and on during the day and evening. Resident to have visibility out of her window when in bed. Resident to receive daily half hour one on one room visits. Resident to have visibility of her family photographs and to be within reach of her stuffed animals.	12/31/13

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F 248	Continued From page 3 newspaper, one asking to go back to her room and two were participating in the activity. At 12:45 P.M. on 11/04/13 resident #5 was in the same position facing the window. No radio on; nor any interaction being conducted by staff with resident. At 4:00 P.M. on 11/04/13 resident #5 briefs were changed and she was placed on her back by a CNA. The radio was not on. The curtains were closed for privacy. After resident was cleaned and changed she was placed on her left side towards the window. The curtains remained closed. According to Management Staff G there was no activity log however the activity director Management Staff D provided logs for August, September and November. Octobers was not accessible. During a review of the clinical records of Resident #5 the Activities In Room Visit record indicated that there were five socializing visits made to the resident in the month of August and September, no record for the month October and no visits thus far for the month of November. The same records also indicated that in August the TV or music had been on nine times and thus far in the month of November, three times - two days of which survey was being performed and no music nor TV were operating. According to resident #5's September Activity Care Plan it stated, the resident ' will be provided room visits two times a week if not more ' and ' will be encouraged to attend musical entertainment '. The Activity Plan also stated that the ' resident will be up at least twice a week ' and that ' music will be played '. Neither of these activities were witnessed during this survey. On November 8, 2013 at 9:15 A.M. resident #5 was positioned on her left side in bed. Her call	F 248	The Social Service Director made rounds to ensure no other residents were effected by this deficient practice. The Activity Director ensured the reading materials in the activity program were current to date. The Activity Director will plan and implement activities that have a wide spread interest or otherwise generate indivudual activities for residents in the actvitly room who may not want to partcipate in the group activity that is scheduled. The Activity Director will supervise the activities of all residents including Resident #5 to ensure the facility remains in compliance. Ongoing issues will be reported and reviewed during the monthly QA commitee meeting. The Activity and Social Service Director is responsible for ongoing compliance.	12/30/13 12/30/13 1/3/14 12/30/13

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F 248	Continued From page 4 bell was within reach, there was no music, no stimuli other than light from the window. Resident #5 has some small stuffed animals up high above the closet behinds some photos of her family members which were out of her sight and touch plus they were not visible for the residentto see. On November 8, 2013 at 10:40A.M. a CNA was caring for the resident #5. According to the CNA, resident #5 used to be very active (singing, praying and talkative) and that she loved music and lovd to sing. According to CB resident #5 could hear and she would blink and move her eyes in response to voice. CNA did not know why her radio was not plugged up with the cord in her drawers.	F 248		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observtion, interview, and policy review, the oxygen concentrators for two residents did not have a label on the tubing indicating when the tubing had been changed. An oxygen concentrator is a machine that is used	F 328	The facility will ensure that residents recieve proper treatment and care for special services Resident #5 in room 6b and Resident #18 in room 23 tubing was changed and labeled with the date in accordance with the facility policy. The Director of Nursing made rounds to ensure no other residents were effected by this deficient practice. The Director of Nursing provided an inservice to the licensed nurses to ensure the nurse on duty labels the tubing with the date the tubing is changed.	11/5/13 12/30/13 1/2/14

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F 328	Continued From page 5 to provide oxygen to a resident in a steady even flow by means of a mask or nasal cannula connected to the concentrator via tubing. Oxygen is ordered by the physician. This failure had the potential to result in the tubing for the oxygen concentrator being used for longer than allowed per policy to prevent contamination by disease causing organisms. Findings: During an observation on 11/4/13 at 9:15 a.m., an oxygen concetrator in use for unsampled Resident 18 in Room 23 did not have a label on the tubing indicating when that tubing had been changed. During an observation and concurrent interview on 11/5/13 at 10a.m., the oxygen concentrator for Resident 5 in room 6B did not have a label on the tubing indicating the date it was changed. Management Staff G stated that the tubing for the oxygen concentrators was changed every Monday by the Licensed Nurse on duty for the day shift. During review of policies for oxygen administration on 11/6/13, a facility document titled Use of Oxygen Humidifies (humidifiers) indicated " Open sealed bag of cannula or oxygen mask. Label mask or cannula with date opened. Change mask or cannula tubing every week."	F 328	Ongoing issues will be reported and reviewed during the QA Committee meeting. The Director of Nursing is responsible for ongoing compliance.	
F 371 SS=F	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	F 371		

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F 371	Continued From page 6 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on food service observations, dietary staff interview, dietary document review and the facility's policy and procedures, the facility failed to ensure safe food handling and distributing practices were followed as evidenced by: 1a) Dietary staff were working from a designated soiled area to a designated clean area where the ware washing (is the collective term used to clean commercial dishes, pots, pans and utensils) are processed and preparing residents' meals without washing their hands and/or changing their aprons; 1b) warewashing racks filled with soiled dishes were used to slide warewashing racks with clean dishes through the mechanical warewashing machine to the clean side of the dishwashing area; 1c) Warewashing racks used for the residents' food preparation and distribution were placed on the dietary department's floor next to the mechanical warewashing machine; 2) Cartons of health shakes that were in a soiled plastic crate container was resting on top of a warewashing rack with clear drinking glasses; 3) Unclean kitchen area- a. the ice machine's exterior panel was covered with dark brownish black particles and the inside filter was not to the manufacturer's specifications,	F 371	The facility will ensure it procures food in accordance with the regulation. Dietary staff were inserviced on the following proceedures to ensure residents would not be further effected by their deficient practice: 1a) Working from a designated soiled area to a designated clean area requires washing hands and changing aprons. 1b) Clean warewashing racks are not to come in contact with warewashing racks with solid dishes. 1c) Warewashing racks will not be stored on the floor next to the mechanical warewashing machine. 2) Health shakes will be properly stored prior to serving. 3a) The ice machine's exterior panel was cleaned and the interior filter was replaced to comply with the manufacturers specifications. 3b) The metal ventilation hood over the gas stove was cleaned.	1/3/14 1/3/14 1/3/14 1/3/14 1/7/14 1/6/14

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F 371	Continued From page 7 and b. the metal ventilation hood over the gas stove had a dark brown sticky residue on it. Lack of effective systems to ensure resident meals and snacks were prepared and distributed utilizing practices that prevented the cross contamination of food may result in residents being exposure to food borne illness. Food borne illnesses may result in gastrointestinal distress, weight loss, hospitalization, a compromise in clinical status and in severe instances may result in death. Findings: 1a, 1b, 1c) During a dietary observation on 11/5/13 at 8:20 a.m., Dietary Staff I, wearing a cloth apron pulled the cover off the air conditioner, walked over to the mechanical warewashing equipment, lifted the right handle with a terry cloth material, pushed clean dishes that were in the warewashing rack through to the clean side; grabbed another warewashing rack from its' shelf, and placed the air conditioner cover into the warewashing rack and into the mechanical warewashing equipment. Dietary Staff I washed her hands with soap and water, gloved, placed the clean kitchenware and tableware in their respective locations and then returned to preparing food for the lunch meal without changing her apron. During this same observation on the floor next to the clean side of the mechanical warewashing equipment (dishwasher) one warewashing rack was lying on its side. Dietary Staff J wore a white plastic apron. He emptied out the tray carts, discarded the unused food, sprayed off the kitchenware and tableware and placed them in	F 371	The Maintenance Supervisor will maintain a schedule to ensure the stove hood is cleaned weekly to ensure compliance. Dietary manager will be responsible for monthly inservices to ensure the staff are educated on proper storage, preparation, distrubution and serving of food in sanitary conditions. Ongoing issues will be reviewed and discussed in the monthly QA Committee meeting.	

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F 371	Continued From page 8 the empty warewashing racks. During a same observation at 10:05 a.m., Dietary Staff J opened the right side (soiled) handle of the mechanical warewashing equipment and pushed the soiled ware rack filled with blue cups against the clean ware rack through to the clean side of the mechanical warewashing equipment. At this point in time there were two ware racks resting on the dietary floor. During the same observation period, Dietary Staff K, wearing a cloth apron, left the dietary department and came back minutes later with a loaf of bread. Dietary Staff K applied gloves, but failed to wash her hands before applying the gloves and proceeded to pull out slices of bread to prepare sandwiches for the residents' lunch. During an interview on 11/6/13 at 8 a.m., Management Staff C stated, "I would expect them [staff] to change their aprons when changing from dirty to clean areas." It would be the standard of practice to ensure that employees wear clean outer clothing to prevent contamination of food, equipment, utensils, linens... (Food Code 2009) Review of the RDs For Healthcare, Inc Policy and Procedure Section 8.2 "Sanitation" indicated under Procedure #20, "A minimum of two employees will be used when dishes are machine washed. One will handle the soiled area and one will handle the clean side. If an employee does need to go from soiled end to clean end, a strict hand washing routine must be followed." 2) During observation of food preparation on 11/5/13 at 11:40 a.m., Dietary Staff K set a soiled	F 371		

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F 371	Continued From page 9 plastic crate container with cartons of health shakes on top of a warewashing rack with clear drinking glasses. During an interview on 11/7/13 at 8 a.m., Management Staff C corroborated that the soiled plastic crate container did not belong on top of clean glasses. 3a) During a general observation of the Dietary Department with concurrent interview on 11/6/13 at 8 a.m., a white paper towel was dampened and swiped across the front edge of the gas range stove's metal vent hood. A dark brown sticky residue adhered to the white paper towel. Management Staff C stated that staff should clean the stove's hood every week. In reviewing the "Dietary Department Weekly Cleaning Schedule" Management Staff C corroborated that cleaning the stove's hood was not included in the schedule. The facility's Dietary Department follows the RDs for Healthcare, Inc.'s ("...is a California company of dietitians and office staff that...[provides] professional service...[of] extended care menus and consulting services) policies and procedures. Policy and Procedure Section 8.1 "Sanitation" indicated under Procedure # 6, "The maintenance department will assist dietary as necessary in maintaining equipment and in doing janitorial duties which the dietary employees cannot do." and # 14 "...and the hood over the stove which will be cleaned by the maintenance staff." During an interview with on 11/7/13at 8 a.m., Management Staff B stated he was not aware he was responsible for cleaning the metal ventilation hood."	F 371		

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F 371	Continued From page 10 In addition, Under Section 8.1, "Hoods, Vents and Filters" includes, 'Hoods' "Hoods must be cleaned every two weeks and must be free of dust and grease." 3b. During a dietary observation on 11/6/13 at 2 p.m., the ice machine's outside panel was covered with dark brownish black particles. During an observation with concurrent interview on 11/7/13 at 8 a.m., Management Staff B corroborated that the outside panel needed to be cleaned. Management Staff B added that since his recent employment he had discovered this particular ice machine has two filters, one of which were missing, so he hand crafted a filter for the inside of the Hoshizaki America, Inc. "Self-Contained Flaker" Model # F-330BAH(-C). Review of the facility's Policy and Procedure titled, "Policy for Ice Machines and Ice Storage Containers" from the 'Infection Prevention Manual for Long-Term Care Facilities' 1998, indicated, "A maintenance inspection of ice machines should be completed on a regular basis, and any necessary repairs made, to ensure that water contamination within the machinery does not occur..."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	The facility will distribute drugs and biologicals in accordance with professional principles, instructions and expiration dates. The vial of Humulin insulin 70/30 was immediately removed from the medication refrigerator.	11/4/13

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	056430	A. BUILDING _____ B. WING _____	11/04/2013

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F 431	Continued From page 11 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, a vial of Humulin Insulin 70/30 for one resident, unsampled Resident 20, had been opened for more than 28 days and was still in use. Insulin is a protein that is used to regulate the use of sugar in the human body. A resident with the diagnosis of insulin dependent diabetes is not able to produce insulin and must be given it every day via injection. A vial of Humulin Insulin 70/30 that has been in use for 28 days must be discarded to prevent contamination from disease	F 431	All other medication with an expiration date was checked to ensure no other residents were effected by this deficient practice. The resident's insulin was replaced with a new vial. The licensed nurses were inserviced on discarding the vial after being opened for use 28 days. The licensed nurses were also inserviced on the policy regarding expired medication. Pharmacist will continue to audit the med cart and medication refrigerator monthly. Ongoing issues will be addresed during monthly QA committe meeting and Quarterly meeting which thr Pharmacist attends. Director of Nursing is responsible for ongoing compliance.	1/3/14

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F 431	Continued From page 12 causing organisms. This failure had the potential to cause contamination of the insulin vial resulting in an infection in the resident with a disease causing organism. Findings: During an observation and concurrent interview on 11/4/13 at 3:30p.m., there was a vial of Humulin Insulin 70/30 U-100 for unsampled Resident 20 in the medication refrigerator in the medication room that was dated 9/20/13 indicating the date the vial had been opened for use. Management Staff G stated that the facility policy indicated that vials of insulin were to be discarded 28 days after being opened for use. During a telephone interview on 11/6/13 at 8:45 a.m., Consultant Staff H stated that there is only one brand of insulin, Levemir, that can be used for 42 days after the vial is opened for use. All other brands of insulin must be discarded after 28 days of use. On 11/5/13 facility all policies and procedures pertaining to insulin were requested from Administrative Staff A. The facility did not provide any policy or procedure that addressed how many days an insulin vial could be used after being opened for use.	F 431		
F 441 SS=F	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.	F 441	The facility will 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.	

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F 441	Continued From page 13 (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 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 review of the facility's policy and procedure, the facility failed to protect residents from potential nosocomial (facility acquired) infections when staff created an environment for cross	F 441	The staff was inserviced on hand washing proceedures and sanitizing betwen residents when distributing water and were provided a copy of the facility policy which states this. The staff was inserviced on proper storage of the scoop used to collect ice for the water pitchers as well as proper handling and of the scoop. Director of Nurses made a count of all water pitchers to ensure there is one for each resident. Extra water pitchers were ordered. Ongoing issues and will be addressed with the QA meeting to be for review and recommendation. Director of Nursing is responsible for ongoing compliance.	1/2/14 1/2/14 1/3/14

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F 441	Continued From page 14	F 441		

contamination (is the physical movement or transfer of harmful bacteria from one person, object or place to another.) when providing residents with fresh water. Nosocomial infections can be caused by viruses, bacteria, fungi or even parasites that can cause the facility's residents, who are already prone to infections because their weakened immune system, to require a longer recovery period or even hospitalization.

Findings:

During an observation on 11/4/13 at 2:40 p.m., Unlicensed Staff were providing fresh water to the residents. Unlicensed Staff were using a plastic three shelf cart on wheels which contained a white plastic ice chest on the top shelf. An arm, when pulled out from under the top shelf was used to rest the water pitchers for convenience while filling the water pitcher with ice. There was a round plastic container that rested on the middle shelf directly below the retractable arm. The hand scoop, which was being used to retrieve ice from the ice chest, was being placed inside the ice chest, resting in the ice when not in use.

Upon further observation, Unlicensed Staff L lifted the lid off the ice chest, placed the inside of the lid face down perpendicular to the ice chest, retrieved the ice scoop with ice from inside the ice chest with Unlicensed Staff L's fingers touching the inside of the scoop containing the ice used for the residents' water pitchers. During this observation Unlicensed Staff L returned the pitcher to Unsampled Resident 21's overhead table, arranged Unsampled Resident 21's stack of papers, live plant, small personal items and water pitcher. Unlicensed Staff then retrieved

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F 441	Continued From page 15 Unsampled Resident 22's and 23's water pitchers performing the same task of pouring the old water out of the pitchers and then filling the pitchers with ice. This pattern was repeated when Unlicensed Staff M discarded the water from the pitcher that was retrieved from the residents' room before filling the water pitchers with fresh ice. During this whole process Unlicensed Staff L and M did not wash their hands with soap and water and did not sanitize their hands between residents. During an observation on 11/6/13 at 2:30 p.m. Unlicensed Staff were observed taking plastic pitchers from the cupboard above the sink next to the water dispenser by the nurse's station. Unlicensed Staff were filling these pitchers with ice from a white plastic ice chest using a scoop. The scoop was initially resting in a holder that was in a retractable holder under the top shelf of the plastic cart. The scoop was being placed inside the ice chest, within the ice, when it was not in use instead of being placed in the holder for which it was intended. In the meantime, other Unlicensed Staff were placing the residents' pitchers which they had retrieved from the residents' rooms on the wooden handrails out in the hallway. These pitchers were placed on the second shelf of the cart and were being replaced with the pitchers of water that were being filled with ice and water. Unlicensed Staff continued the process for the East Wing. During this process of replacing the water pitchers from the residents' room with the pitchers from the cupboard the staff did not wash their hands with soap and water or sanitize their hands.	F 441		

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F 441	Continued From page 16 Unlicensed Staff N was changing out the water pitchers in the West Wing. As she was walking room to room a resident in a wheelchair who was out in the hall dropped a piece of paper in which Unlicensed Staff N picked up the paper for the resident and continued on passing out the water pitchers; without washing her hands with soap and water or sanitizing her hands. This process continued through room 22 at which time Unlicensed Staff N used the hand sanitizer located outside the resident's room. When queried about the use of the hand sanitizer Unlicensed N responded, "When I saw you watching me I started to use the sanitizer and continued on to say, "There are not enough dispensers." When asked who is responsible for passing the water pitchers Unlicensed Staff N responded, "All CNAs (certified nurse assistants helps patients or residents with healthcare needs under the supervision of a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN)) are responsible for passing the water pitchers." During an observation on 11/5/13 at 11a.m., the ice chest was outside in the yard behind the kitchen. Dietary Staff J stated he was responsible for cleaning and sanitizing the ice chest/cart. Dietary Staff J described the process he follows for cleaning and sanitizing the ice chest/cart. During an interview on 11/6/13 at 3:10 p.m. Management Staff G stated the current process for dispensing fresh water to the residents "are unacceptable." Review of the facility's policy and procedure titled, "Policy for Ice Machines and Ice Storage Containers" indicated, "All personnel should be	F 441		

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F 441	Continued From page 17 instructed on the following to reduce contamination of ice ...Wash hands before obtaining ice...Hold the scoop only by the handle ..."	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure the residents' assistive devices (These are tools, products or types of equipment that help residents perform tasks and activities. [Medline]) were taken care of through securing a storage space, routine maintenance, and clean and sanitary equipment. The equipment being stored was without identification of whether the equipment was clean, soiled, or in good repair. This failure had the potential for residents that require assistive devices to use unsanitary and unsafe equipment. Findings: During an Environmental Tour observation with concurrent interview on 11/4/13 at 3:20 p.m., revealed that immediately outside the West Wing's exit door to the right, under the eaves exposed to the elements was a wheelchair, two walkers, and two commodes. Initial inspection of the equipment indicated there was no labeling to indicate whether the equipment was clean, dirty or in need of repair. Management Staff B stated	F 456	The facility will maintain all essentisl mechanical, electrical and patient care equipment in safe operating condition. The items stored outdoors were inspected, cleaned, labeled with the date and properly stored. The maintenace supervisor made rounds to ensure all equipment outdoor was inspected, cleaned labeled and stored to ensure no other resident equipment was effected by this deficient practice. A cleaning schedule for wheelchaurs and assistive devices was uodated and added to the maintenace supervsors monthly rounds. The policy and proceedure regarding assistive devices related to cleaning was located by the administrator and provided to the maintenance supervisor. Ongoing issues will be reviwed at the QA Committe meeting for recommendations.	12/31/13 1/3/14 1/2/14 1/3/14

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F 456	Continued From page 18 that storage space is limited and he had not had the opportunity to organize the equipment since he had recently taken on the responsibility of his new position. During the same tour, located in the back of the facility behind the East Wing, a large storage container held more equipment utilized by residents. When Management Staff B was queried on how staff could identify which equipment was clean and/or usable when needed, he was unable to respond. During a document review with a concurrent interview on 11/6/13 at 7:35 a.m., Management Staff B presented a newly created cleaning schedule for the residents' wheelchairs on the "East and West side" of the facility. Other assistive devices were not included in the schedule. A request was made for the policy and procedures regarding assistive devices related to the cleaning, the maintenance and the storage of resident care equipment. During the course of the survey no policy and procedure was provided.	F 456	Maintenace Supervisor is responsible for ongoing compliance.	
F 466 SS=F	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced	F 466	The facility will establish procedures to ensure that water is available to essential areas when there is a loss of normal warer supply.	

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F 466	Continued From page 19 by: Based on observation, interview, and policy review, the facility failed to have a policy and procedure that was available for staff's reference on how to discharge, contain, transport, and distribute water from the facility's four water heaters in the event there was a loss of normal water supply in an emergency or disaster. This failure has the potential for staff to be unable to meet the needs of the residents in an emergency/disaster. Findings: During an observation and concurrent interview on 11/4/13 at 3 p.m., Management Staff B was asked to demonstrate how to discharge, contain, transport, and distribute water from two of the four water heaters in the facility's basement near the laundry (each water heater contained 100 gallons) in the event of a disaster. Management Staff B was not able to demonstrate the process on how to discharge, contain, transport, and distribute water from either of the water heaters. There were no equipment, tools or directions available to guide the accessibility, containment, transportation and distribution for the emergency water supply. In addition, there was not a clear sense of the location of two of the four water heaters that were mentioned in the Policy and Procedure titled, "Emergency Water Supply" dated with a revision date of 1/1/2011 indicated under subtitle, 'Distribution of Emergency Water' [bullet six]...In the event that the water supply in the toilet and tanks and/or water heaters need to be used, the Administrator, or designee will ensure that staff	F 466	The updated policy and proceedure for the Emergency Water Supply was provided to the staff in an inservice. The updated policy and proceedure was included in the Disaster Manual. The outstanding materials needed to remove and distribute water from the four water heaters was identified, labeled and the location of items was added to the disaster manual under Emergency Water Supply. All other disaster policies were audited to ensure they were current. Ongoing issues will be addressed during the QA committe meeting. Maintenace supervisor is responsible for ongoing compliance of the water supply.	1/3/14 1/3/14 1/3/14 1/2/14

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F 466	Continued From page 20 has enough water pitchers to transport this supply to the kitchen for purification." (This policy was provided by Meridian Foresight, former proprietors of the facility.) In addition, Administrative Staff A provided a policy which across the top of the page in hand writing stated, "Admistrative Policy Procedure" with no indication of a date for initiation, review or revision of this policy. At the bottom of the page, "Fire and Disaster Manual, WEBB Fire Protection, Inc." is named. At the top of this particular page the following information is listed: Main Gas Shut Off Location _____ Main Water Shut Off Location _____ Main Electrical Shut Off Location _____ Emergency Food Supply Location _____ Emergency Water Supply Location _____ Disaster Kit Location _____ All of the above blanks were not completed. During an observation and concurrent interview on 11/7/13 at 10:30 a.m., Managment Staff B and Managment Staff C were not able to describe nor demonstrate the plan on how to discharge, contain, transport and distribute the water from all four of the water heaters in the event of an emergency/disaster.	F 466		
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in	F 516	The facility must safeguard clinical record information againat loss, destruction, or unauthorized use.	

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F 516	Continued From page 21 accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and the facility's policy and procedure the facility failed to safeguard one of 12 Sampled Residents (Sampled Resident 7) and four Unsampled Residents (13, 15, 16, 17) thinned (is when selected documentation from the resident's current medical record is removed when the chart becomes too large to handle) or closed charts which were stored in the facility's shared storage area in the basement accessible to unauthorized personnel. This method of storing residents' clinical records has the potential for a breach of confidentiality for all facility residents. Findings: During the Environmental Tour with a concurrent interview on 11/5/13 at 3 p.m. two of the file cabinets which contained residents' confidential medical records were unlocked. Management Staff B stated he did not know anything about the unlocked files. During an interview on 11/7/13 at 11:50 a.m. Administrative Staff O and Management Staff D stated they currently do not have a designated Medical Records person; however they are in the hiring process. Staff offered the explanation that the business office had been searching for documents requested by another entity.	F 516	The cabinets containing the medical records were immediately locked. All other cabinets were checked to ensure the meducal records were secured. Administrative staff and management staff was inserviced in keeping the records locked at all times. The facility has hired back their previous medical records director. The policy and proceedure will be updated to reflect a date of implementation and review at the QA meeting next month. Medical records director is responsible for ongoing compliance.	11/5/13 11/5/13 12/27/13 11/27/13 1/2/14

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F 516	Continued From page 22 Administrative Staff O stated the file cabinet had probably been open for 48-72 hours. Review of the facility's policy and procedure titled, "Retrieval, Access, Confidentiality by Facility Staff" with no date indicating the implementation, review or revision of this policy. The policy state, "The Record Department or storage areas shall not be left unlocked or unattended at anytime. "	F 516		