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

POC accepted 8/8/11 RN

PRINTED: 07/29/2011
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
	056195	A. BUILDING HEALTH FACILITIES INSPECTION DIVISION B. WING ADMINISTRATION	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK PARK REHABILITAION CENTER	505 N. LA BREA AVENUE LOS ANGELES, CA 90036

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: [redacted] RN - HFEN [redacted] RN - HFEN [redacted] RN - HFEN [redacted] RN - HFEN [redacted] REHS - HFE I Total Resident Population: 121 Total Resident Sample: 24 Highest Severity and Scope: E	F 000	**Please accept this plan of correction as our credible allegation of compliance.** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the Health and Safety Code Section 1280 and CFR 405.1907.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to resolve grievances the residents had related to the long waiting time for the nursing staff to answer the residents' call lights. The residents complained about the delay in answering call lights in three consecutive council meetings, and by 6/29/11, the grievance was not resolved. This deficient practice caused the resident lengthy wait for assistance.	F 166	FTAG 166 SS = E **Director of Nursing** initiated an in-service on **7/5/11** and **7/6/11** to licensed nurses and **Director of Staff Development** conducted an in-service to CNA'S and other staff on **7/8/11** and **7/12/11** respectively regarding prompt response to call lights. **Social Service Designee** re-interviewed resident # **4,9,14,26,6,2** and **20** on **7/7/11** regarding call light prompt response and verbalized its improvement in length of response. **Assistant Administrator** randomly interviewed alert residents on **7/7/11** and no significant issues on call light were identified.	7/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8/8/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 Findings: On 6/29/11, at 1:30 p.m., during a group interview, four of 16 residents attending the meeting (Residents 4, 9, 14, and 26) complained their main problem living in the facility, was waiting for extended periods of time before nursing staff responded to their call for assistance. The residents stated they were frustrated waiting for so long. Some of the residents further indicated that at times, the staff did not respond at all. On 6/29/11, at 11:30 a.m., on 7/5/11, at 10:15 a.m., and on 7/5/11, at 10:45 a.m., individual interviews conducted with Resident 6, 2, and 20, respectively, revealed the residents complained the staff response time to call lights was frequently poor. A review of the Resident Council Meeting Minutes dated 4/11/11, on the page titled Old Business Needing Further Actions, the following note was found under #1: "Call lights - Still a problem - Not to 15 minutes yet". The Resident Council Minutes dated 5/16/11, on the page titled Old Business Needing Further Actions, the following note was found under #1: "Call lights improved to 15-20 but would like us to continue to focus on." The Resident Council Minutes dated 6/13/11, on the page titled Old Business Needing Further Actions, the following note was found under #1: "Call lights - improving, 3-11 mostly now, particularly from 10-11 p.m." On 7/7/11, at 2:30 p.m., during an interview, the administrator was unable to explain why the	F 166	**Director of Nursing** did visual rounds and observation on 7/7/11 and no other residents were affected by the deficient practice identified. **RN Supervisors** will do visual rounds and observation every shift and document findings to the 24 hours endorsement log for compliance and report findings to the Director of Nursing. **Director of Nursing** will do random visual observation and rounds weekly to ensure compliance and report findings to the daily stand up Department Managers meeting. **Administrator** will follow up findings from the Resident Council meeting monthly and discuss updates and improvements to the daily stand up Department Managers Meeting . **Administrator** will follow up and discuss findings to the Quality Assurance meeting monthly. **DATE OF CORRECTION 7/7/11**	

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F 166	Continued From page 2 residents' continued complaints/grievances related to call lights had not yet been resolved.	F 166		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained each resident's dignity and respect for two of 24 sample residents (9, 20), and two randomly selected residents (25, 27). Residents 9 and 20 were told by nursing staff to urinate in bed rather that assisting them to use the toilet. Residents 25 and 27 were not provided with visual privacy. This deficient practice caused residents to feel upset about the lack of assistance received and subjected residents to be unnecessarily exposed. Findings: 1. On 6/29/11, at 1:30 p.m., during a group interview, Resident 9, with tears in her eyes and visible upset, complained that she frequently experienced waiting for extended periods of time before nursing staff responded to her call for assistance with toilet use, only to have that staff member tell her, "Just go ahead and relieve yourself, I will clean you up later." A review of the clinical record revealed the	F 241	FTAG 241 SS = E **Resident #20** was reassured immediately of assistance when needed on **7/5/11.** **Resident # 25** and **# 27** was covered immediately for privacy on **7/5/11.** **Director of Staff Development** initiated one on one in-service to CNA assigned to **resident # 25** regarding privacy. **Director of Nursing and Director of Staff Development** initiated an in-service to Licensed Nurses and CNA'S on **7/6/11, 7/8/11, and 7/12/11** respectively regarding Dignity, incontinence care and Privacy as per Facility Policy and Procedures. **Director of Nursing** followed up with random visual observation on **7/6/11 and 7/11/11** and no other residents were affected by the deficient practice identified. Assistant Administrator did random interview to alert residents regarding dignity and privacy and no other issues identified. **Assistant Director of Nursing** and **RN Supervisors** will do daily rounds and visual observation to all residents and report findings to the Director of Nursing. **Administrator** will follow up and discuss findings in the Quality Assurance Meeting Monthly. **DATE OF CORRECTION 7/11/11**	7/11/11

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F 241	Continued From page 3 resident was readmitted to the facility on 8/11/10, with diagnoses which included knee joint replacement, hypertension, disc degeneration, and anemia. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/22/11, indicated the resident had no memory problem, was incontinent of bowel and bladder functions, required extensive assistance with transfer, locomotion, and toilet use. 2. A review of the clinical record revealed Resident 20 was readmitted to the facility 6/17/11, with diagnoses that included muscle weakness, convulsions, chronic airway obstruction, and hypertension. On 7/5/11, at 10:45 a.m., during an individual interview, the resident was alert and oriented to person, time, place, and circumstances. Resident 20 stated he needed assistance by nursing staff to use the toilet. The resident's physical demeanor, facial expression, and verbalizations changed markedly as he began describing how he felt when a nursing staff member told him, "Just urinate in the bed. I will get you cleaned up when I get here." The resident, trembling with anger, stated he was, "Outraged that anyone would suggest that he should do such a thing." 3. On 7/5/11, at 8:50 a.m., Resident 25 was observed in the hallway, sitting in a shower chair and covered with a bath blanket. Certified nursing assistant 1 (CNA 1), wheeled the resident from the shower room, back to the resident's room. Once in the room, CNA 1 handed a towel to the resident to dry herself and CNA 1 made the	F 241		

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F 241	Continued From page 4 resident's bed. The privacy curtain was not closed and the bedroom door was left open. The resident could be viewed from the hallway drying her uncovered body with a towel. A review of the clinical record revealed the resident was readmitted to the facility on 8/21/09, with diagnoses that included difficulty in walking, osteoporosis, and arthropathy. A care plan dated 2/2/11, indicated the resident had impaired cognitive function, required extensive assistance with transfers, walking, personal hygiene, and dressing. On 7/5/11, at 3:15 p.m., during an interview, CNA 1 stated she knew the resident's privacy should be protected. CNA 1 stated she gave the resident a towel to dry herself but forgot to pull the window curtains, privacy curtains, and to close bedroom door. 4. On 7/5/11, at 11 a.m., Resident 27 was observed sitting in a wheelchair at Nurses Station A. Next to the resident, there were two staff member from a transportation van, getting ready to transfer the resident unto a gurney to an outside dialysis center. The resident was dressed in a thin short cotton dress, with three buttons missing at the bottom of the dress. The extent of the resident's thighs were exposed. At the time of the observation, the resident stated she was cold and would like to have a cover over her legs. A Registered Nurse (RN) supervisor, was standing by the Nurses Station desk, and when the Evaluator brought to the RN's attention the resident's request, she agreed that the resident's upper legs and thighs needed to be covered. The	F 241		

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F 241	Continued From page 5 RN got a bath blanket to cover the resident's legs. A review of the clinical record revealed the resident was admitted to the facility on 6/28/11, with diagnoses that included renal failure, chronic kidney disease Stage V, on hemodialysis treatment three times per week, and arthritis. A care plan dated on admission indicated the resident required encouragement to participate in activities of daily living (ADL's) care.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate the resident's needs for one of 24 sample residents (12). Resident 12 was not provided with a bed that accommodated to his height, causing his feet to be against the footboard. This deficient practice had the potential to cause injury and discomfort to the resident's feet. Findings: On 6/29/11, at 9:35 a.m., during an observation	F 246	FTAG 246 SS = D **Resident # 12** bed was replaced into a longer bed on **6/29/11** . Maintenance Supervisor checked all residents bed and no other residents were affected by the deficient practice identified **All CNA's and Licensed nurses** will report daily any issues of bed upon admission. **Maintenance Supervisor** will do random rounds weekly to ensure all beds are appropriate and report findings to the Administrator. **Administrator** will do follow up rounds weekly for compliance and discuss findings to the daily stand up Department Managers Meeting. **Administrator** will discuss findings and follow up in the Quality Assurance meeting Monthly. **DATE OF CORRECTION 6/29/11**	6/29/11

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F 246	Continued From page 6 with the presence of the treatment nurse, Resident 12 was lying in bed, with his feet against the footboard of the bed. The treatment nurse repositioned the resident to the upper part of the bed, however, the length of the bed was about the same length of the resident. The resident was noted with redness on the soles of the feet (the area against the footboard). The redness disappeared after few minutes. The treatment nurse stated the resident needed a longer bed. A review of the clinical record indicated the resident was readmitted to the facility on 3/25/11, with diagnoses that included history of stroke, diabetes mellitus, and altered mental status. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 4/5/11, indicated the resident had memory problems, was severely impaired for daily decision-making, had pressure sores, and required extensive assistance with bed mobility. An Arterial Study of Lower Extremities report dated 6/3/11, indicated the resident's arterial perfusion distal to bilateral ankles may be markedly to severely compromised with increased severity on the right. A care plan dated 6/7/11, indicated the resident was at risk for skin breakdown. A Nurses Progress Notes form dated 6/28/11, indicated the resident's family requested for the footboard of the bed to be removed, because the resident was tall and his feet touched the footboard. A physician's order was given on 6/28/11, to remove the footboard in the morning.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	FTAG 309 SS =D **Resident #12** was reassessed and updated records accordingly on 7/7/11.	

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F 309	Continued From page 7 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate monitoring of an stasis ulcer for one of 24 sample residents (12). Resident 12's right heel arterial ulcer weekly assessment was incomplete in order to determine progress of the wound and effectiveness of treatment. This deficient practice had the potential for lack of identification of care needs. Findings: On 6/29/11, at 10:10 a.m., a treatment observation revealed Resident 12 had a superficial wound on the right heel with a whitish colored wound bed. A clinical record review revealed the resident was readmitted to the facility on 3/25/11, with the diagnoses that included Clostridium Difficile infection (C-Diff - a type of bacteria that can cause lower abdominal discomfort, bloating, and loose stools), hypertension, and atrial fibrillation. The Minimum Data Set (MDS -standardized assessment and care planning tool) dated 4/5/11, indicated the resident had memory problems, was	F 309	**Director of Nursing and Treatment Nurse** reviewed resident records and reassessed residents on **7/7/11 and 7/8/11** and no other residents were affected by the deficient practice identified. **Director of Nursing** Initiated an in-service on **7/5/11 , 7/14/11 and 7/20/11** to all treatment nurses and licensed nurses regarding documentation and assessments per Facility Policy and Procedures. **Director of Nursing** will do follow up in-service to licensed nurses and treatment nurses for updates quarterly and as needed. **Director of Nursing** will do random observation to all treatments and review documentations weekly . **Medical Records Director** will do audit weekly on treatment assessments and documentation weekly and report findings to the administrator and Director of Nursing for compliance. **Administrator** will do follow up up and discuss findings to the Quality Assurance Meeting monthly. **DATE OF CORRECTION 7/20/11**	7/20/11

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F 309	Continued From page 8 severely impaired for daily decision making, was continent of bowel, and required extensive to total care. An Arterial Study of Lower Extremities report dated 6/3/11, indicated the resident's arterial perfusion distal to bilateral ankles may be markedly to severely compromised with increased severity on the right. According to the Non-Pressure Ulcer Weekly Skin And Wound Report form dated 6/7/11, the resident was identified with an arterial stasis ulcer, a redness, on the right heel. The size of the ulcer was not documented. The physician ordered treatment to the affected area. A plan of care dated 6/7/11, developed for the resident's risk for further breakdown due to low blood flow in the lower extremities and presence of a right heel stasis ulcer, included in the approaches to monitor the skin for signs and symptoms of infection, provide treatment as ordered, and monitor for effectiveness of the treatment. Further review of the weekly progress of the right heel stasis ulcer dated 6/9/11, 6/17/11, 6/24/11, and 7/1/11, included the size of the wound, however, there was no assessment of color, depth, odor, and drainage, in order to determine the progress of the wound, effectiveness of the treatment, and presence of complications such as infection. On 7/7/11 at during an interview, the director of nursing stated the assessment of the stasis ulcer should be complete.	F 309		

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F 309	Continued From page 9 The undated policy and procedure for Pressure Ulcer Management indicated to document the status of of the ulcers. The documentation documentation should include depth, wound base color, drainage, odor, The undated No-Pressure related Wounds And Skin Conditions indicated to perform a complete assessment of the wound.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement measures to promote healing of pressure sores and prevent further skin breakdown for three of 24 sample residents (11, 12, 16). Resident 16 was not provided with a heel protector as ordered and as indicated in the plan of care. Resident 12 did not have a pressure relieving device applied to the feet when in the wheelchair and the care plan did not include approaches to relieve pressure and monitor incontinence while he sat in the wheelchair. Resident 11 had a Stage II pressure ulcer (full thickness tissue loss) on the	F 314	FTAG 314 SS = D **Resident # 16** was immediately provided heel protector on **7/5/11.** **Resident # 12** was immediately provided heel protector and wheelchair pad on **7/1/11.** **Resident # 11** back was kept off from pressure immediately on **7/5/11** and Low Airloss Mattress was provided. **Director of Nursing and Treatment nurse** reviewed and checked all residents needing pressure relieving devices and special mattresses on **7/5/11** and **7/6/11** and no other resident were affected by the deficient practice identified. **Director of Nursing** initiated an in-service on **7/5/11** and **7/14/11** to licensed nurses and treatment nurses regarding application of, and providing pressure relieving devices and special mattresses to high risk residents. **RN Supervisors** will do visual rounds daily and report findings to the Director of Nursing. **Director of Nursing** will do random visual observation weekly for compliance	7/14/11

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F 314	Continued From page 10 sacrococcygeal area, and the area was not kept off of pressure. This deficient practice may delay the healing of pressure sores and may increase the residents' risk for skin breakdown. Findings: 1. On 7/5/11, at 2 p.m., and at 5 p.m., with the presence of Licensed Vocational Nurse 1 (LVN 1), Resident 16 was observed awake, lying in bed with a Stage I pressure sore (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on the left heel. The resident was not wearing a heel protector and the left heel was not kept off pressure. At the time of the observation, the resident stated she did not use heel protectors or any other device for the foot while in bed. On 7/5/11, at 2:20 p.m., during an interview, the assistant director of nursing (ADON) acknowledged the resident was not provided with a pressure relieving device to keep off the pressure sore when the resident was in bed. A review of the clinical record revealed the resident was admitted to the facility on 6/20/11, with diagnoses that included diabetes mellitus, end stage renal disease, status post right above knee amputation, atrial fibrillation, and hypertension. The admission Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/1/11, indicated the resident had memory problems, was moderately impaired in cognitive skills for daily decision-making, and needed total assistance with all activities of daily living (ADLs) including bed mobility and transfers. The resident	F 314	and discuss findings to the daily stand up Department Managers Meeting. **Director of Nursing** will do follow up in-service on procedural updates quarterly and as needed. **Quality Assurance Nurse** will do random visits and visual observation monthly and report findings to the Director of Nursing and Administrator for follow up. **Administrator** will do follow up and discuss findings to the Quality Assurance Meeting monthly. **DATE OF CORRECTION 7/14/11**	

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F 314	Continued From page 11 was incontinent of bowel and bladder functions, and was assessed at risk for developing pressure ulcers. According to the nurse's notes and physician's orders, on 7/1/11, the resident was identified with a Stage I pressure sore on the left heel measuring 7 centimeters (cm) in length by 6.8 cm. in width. The physician ordered treatment and to provide a heel protector. A plan of care developed on 6/21/11, for the resident's high risk for skin breakdown, included in the approaches the use of heel protectors as pressure relieving device. 2. On 6/29/11, at 9:47 a.m., during a treatment observation, Resident 12 had a superficial open wound on the right heel, approximately 1 centimeter (cm) in length. The resident's left leg and right foot had dry and thick peeling skin. During observations on 6/29/11, at 11:10 a.m., and on 7/1/11, at 8:10 a.m., and at 8:35 a.m., the resident was sitting in a wheelchair with the feet resting on the footrests of the wheelchair without a protective padding or pressure reducing devices applied. On 7/1/11, at 10:40 a.m., during another observation and an interview with the director of nursing (DON), she indicated the resident needed heel protectors. A review of the clinical record revealed the resident was readmitted to facility on 3/25/11, with diagnoses that included hypertension, atrial fibrillation, and altered mental status. According to the admission nursing assessment, the resident was admitted with Stage II pressure	F 314		

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F 314	Continued From page 12 sores to the sacrococygeal area (resolved on 5/23/11), and the right and left heels. The MDS dated 4/5/11, indicated the resident had memory problems, was severely impaired for daily decision-making, had pressure sores, and required extensive to total assistance with all ADLs. An Arterial Study of Lower Extremities report dated 6/3/11, indicated the resident's arterial perfusion distal to bilateral ankles may be markedly to severely compromised with increased severity on the right. The Braden Scale-Predicting Pressure Sore Risk form dated 6/17/11, indicated the resident was at high risk to develop pressure sores. Further record review revealed the plan of care since admission, developed for skin integrity problems, did not include the use of pressure relieving devices on the feet to prevent pressure when the feet rested directly on the footrests. In addition, the care plan indicated in the approaches to follow a turning and positioning program, and to keep the resident clean and dry. However, on 7/1/11, at 11:48 a.m., during an interview, the certified nursing assistant (CNA) assigned to the resident, stated the resident was usually up in the wheelchair from 8 a.m. until after lunch., when he was assisted back to bed. The CNA indicated the resident remained in the wheelchair for over a four-hour period. The CNA did not say she monitored for incontinence and/or repositioned the resident to relieve pressure while the resident was sitting in the wheelchair. According to the facility's policy and procedure on Pressure Ulcer Management, the interdisciplinary	F 314		

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F 314	Continued From page 13 team will assure preventative measures for residents at risk for skin breakdown including pressure-reducing devices for chair, turning and repositioning in chair, use of heel protectors, and moisturize skin to prevent dryness as appropriate. 3. On 6/28/11, at 9:30 a.m., on 6/29/11, at 9:10 a.m., and on 7/5/11, at 10:35 a.m., Resident 11 was observed lying in bed over a foam mattress. On 6/2 8/11, at 1:40 p.m., the resident was lying in bed on her back with the head of bed elevated to approximately 30 degrees. A review of the clinical record revealed the resident was readmitted to the facility on 6/17/11, with diagnoses that included heel pressure ulcer, atrial fibrillation, and rheumatoid arthritis. The Nursing Admission Assessment dated 6/17/11, indicated the resident had a Stage II pressure sore on the sacrococcygeal area, a right heel Stage I pressure sore, and a left heel cellulitis. The MDS assessment dated 6/28/11, indicated the resident had memory problems, was incontinent of bowel and bladder functions, and required extensive assistance with transfers and bed mobility. A care plan dated 6/18/11, developed for the resident's alteration of the skin (pressure sore) related to poor bed mobility and bedfast, included in the approaches the use of pressure relieving devices (specified a low air loss mattress) and to follow a turning and positioning program. However, there was no low air loss mattress in the bed but a foam mattress and the positioning program did not include to keep the resident off of her back to promote healing of the	F 314		

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F 314	Continued From page 14 sacrococcygeal pressure sore. On 7/5/11, at 1:40 p.m., during an interview with Charge Nurses 1 and 2, and the Certified Nursing Assistant (CNA) assigned to the resident, they confirmed the resident was repositioned every two hours including resting on her back.	F 314		
F 323 SS=D	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, interview, and record review, the facility failed to ensure each resident receives adequate assistance devices to prevent accidents for one of 24 sample residents (1) and one randomly selected resident (29). Resident 1 was transferred without the use of a gait belt, resulting in the certified nursing assistant (CNA) accidentally stepping on the resident's foot. Resident 29 was transferred by one person using a mechanical lift instead of being transferred by two persons and the mechanical lift. This deficient practice caused the resident to have pain on the right foot and placed the resident at risk for injury by not using two persons assist when transferring the resident using a mechanical lift.	F 323	FTAG 323 SS = D **Resident # 1** is no longer in the facility and was discharge to home on **7/19/11.** **Resident # 29** was reassessed immediately on **6/28/11** and no injury noted from transfer. **Director of Staff Development** initiated one on one in-service immediately to the CNA assigned to resident **# 1 and # 29** and to all CNA'S on **6/28/11** regarding transfers using gait belts and Mechanical lifts **Director of Staff Development** initiated visual rounds and observation on **6/28/11** and no other residents were affected by the deficient practice identified. **RN Supervisors and Charge Nurses** will do visual rounds daily and report findings to the Director of Nursing. **Director of Nursing** will do follow up visual observation weekly for compliance and discuss findings to the daily stand up department managers Meeting. **Quality Assurance Nurse** will do random visits and visual observation monthly and report findings to the Administrator and Director of Nursing.	6/28/11

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F 323	Continued From page 15 Findings 1. On 6/28/11, at 10 a.m., Resident 1, who was in the room, could be heard from the hallway yelling, "Your hurting me, oh, stop your hurting me!" Upon entering the room to investigate why the resident was yelling, the resident was observed sitting in a wheelchair and certified nursing assistant 1 (CNA 1) was standing by the resident. The resident stated CNA 1 hurt her by stepping on her foot, when CNA 1 assisted her into the wheelchair. The resident said, "That's my bad foot (pointing at the right foot) you stepped on, oh, it hurts." A review of the clinical record revealed the resident was admitted to the facility on 6/16/11, with diagnoses that included diabetes mellitus, rheumatoid arthritis, and peripheral neuropathy. The Minimum Data Set (MDS -standardized assessment and care planning tool) dated 6/26/11, indicated the resident had no memory problems, was not able to walk and required one person physical extensive assistance with transfers (between bed and wheelchair), dressing, and personal hygiene. A plan of care dated 6/24/11, indicated the resident required extensive assistance with transfer and the use of a front wheel walker when standing. According to the facility's policy and procedure on Lifting and Transferring of Residents, residents who require assistance in transferring are transferred using a gait/transfer belt or with a mechanical lift. Lifting and transferring of residents is indicated in the resident's plan of care and MDS.	F 323	**Administrator** will follow up and discuss findings to the Quality assurance Meeting Monthly. **DATE OF CORRECTION 6/28/11**	

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F 323	Continued From page 16 On 6/28/11, at 10:30 a.m., during an interview, CNA 1 stated she put the resident in the wheelchair and acknowledged she did not use a gait belt and a front wheel walker while transferring the resident. 2. On 7/5/11, at 10:45 a.m., CNA 1 was observed transferring Resident 29 from bed to the wheelchair with a mechanical lift. The space next the the resident's bed was small and crowded with a bedside table, and over-bed table, a wheelchair, and various medical equipment. CNA 1 seemed to have trouble maneuvering the resident in the mechanical lift to safely lower the resident into her wheelchair. CNA 2 yelled from another room asking if CNA 1 needed assistance, CNA 1 just continued to struggle and maneuvering the resident in the lift to lower her down to the wheelchair. CNA 2 came to the room to assist CNA 1. A review of the clinical record revealed Resident 29 was readmitted to the facility on 1/7/08, with diagnoses that included chronic pain syndrome, generalized muscle weakness, osteoarthritis, mental disorder, and Bell's palsy. The MDS dated 6/1/11, indicated the resident had impaired memory, was unable to communicate, had contractures to the upper and lower extremities, required total care, and two persons assistance with transfers. A plan of care dated 12/2/10, developed for the resident's impaired physical mobility, indicated the resident needed total assistance by two persons.	F 323		

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F 323	Continued From page 17 The facility's policy and procedure on Lifting and Transferring of Residents, indicated residents who require assistance in transferring are transferred using a gait/transfer belt or with a mechanical lift. Lifting and transferring of residents is indicated in the resident's plan of care and MDS.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper foot care for one of 24 sample residents (9). Resident 9 was first seen by the podiatrist four after admission. This deficient practice posed a risk for complications from lack of foot care. Findings: On 7/5/11, at 11:30 a.m., during a treatment observation, Resident 9 was observed with a dressing on the left great toe. Licensed Vocational Nurse 1 (LVN 1), removed the	F 328	FTAG 328 SS= D **Social Service Designee and Treatment nurses** reviewed and checked residents needing podiatry consult on **7/5/11 and 7/6/11** respectively and no other residents were identified and affected by the deficient practice identified. **Director of Nursing Initiated** an in-service on **7/5/11 and 7/14/11** regarding podiatry consult per Facility Policy and procedures. **Medical Records Director** will do audits and review on resident records weekly regarding timeliness of podiatry services and report findings to the Director of Nursing and Administrator. **Director of Nursing** will do random Review and visual observation on residents needing podiatry consult weekly and discuss findings to the daily stand up Department Managers Meeting. **Social Service Designee** will review resident logs after admission for residents needing podiatry consults and communicate updates to nursing department monthly.	7/14/11

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F 328	Continued From page 18 dressing, and the left great toe was noted swollen and with drainage. At the time of the observation, the resident stated she had an infected ingrown toenail. The resident complained that after she was initially admitted to the facility was not seen by a podiatrist for several months. A review of admission record revealed the resident was admitted to the facility on 3/16/10, and readmitted on 8/11/10, with diagnoses that included anemia, status post joint knee replacement, depressive disorder, and hypertension. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/24/11, indicated the resident had no memory problems and required limited to extensive assistance with all activities of daily living (ADLs), except eating. A physician's order dated on admission 3/16/10, indicated podiatry care as needed (PRN). However, further record review revealed that the first podiatry evaluation was dated 7/28/10, four months after admission. The last podiatrist evaluation was dated 6/28/11, when the resident was identified with a left ingrown toenail and a treatment was ordered. On 7/5/11, at 2:20 p.m., during an interview, the assistant director of nursing (ADON) stated the resident should have been referred to the podiatrist by the social service after her admission to the facility. On 7/5/11, at 3:40 p.m., during an interview, the social services assistant stated she would have made the referral to the podiatrist, if nursing had	F 328	**Administrator** will follow up and discuss findings to the Quality Assurance Meeting monthly. **DATE OF CORRECTION 7/14/11**	

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F 328	Continued From page 19 notified her upon admission.	F 328		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services for seven of 24 sample residents (2, 4, 6, 9, 14, 20, 22), and one randomly selected resident (26). For these residents, the staff did not respond promptly, when the resident's called for help verbally or by activating the call light system in their room because they needed assistance. This	F 353	FTAG 353 SS = E **Director of Nursing** initiated an In-service immediately on **7/5/11** and **7/6/11** to licensed nurses and **Director of Staff Development** conducted an in-service to CNA'S and other staff on **7/8/11** and **7/12/11** respectively regarding prompt response to call lights. **Social Service Designee** re-interviewed resident # **2,4,6, 9,14,20,** and **22** on **7/7/11** regarding call light prompt response and verbalized its improvement in length of response. **Assistant Administrator** randomly interviewed alert residents on **7/7/11** and no significant issues on call light were identified. **Director of Nursing** did visual rounds and observation on **7/7/11** and no other residents were affected by the deficient practice identified. **RN Supervisors** will do visual rounds and observation every shift for compliance and report findings to the Director of Nursing. **Director of Nursing** will do random visual observation and rounds weekly to ensure compliance and report findings to the daily stand up Department Managers meeting. **Director of Staff Development** will do follow up in-service on call light prompt	7/7/11

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F 353	Continued From page 20 deficient practice impeded the residents to receive prompt assistance when needed. Findings: 1. On 7/1/11, at 12:34 p.m., Resident 22, who was in the room, was heard from the hallway, calling for help. There were nursing staff in the hallway, however, no staff member responded to the resident's call for help. Upon entering the resident's room, the Evaluator observed the resident in bed lying on his back, stating he had just vomited and needed help. The Evaluator called the nursing staff in the hallway and a licensed nurse supervisor went into the room to assess the resident. There was brownish liquid on the floor by the resident's head of the bed. A review of the clinical record revealed the resident was admitted to the facility on 5/24/11, with diagnoses that included altered mental status, diabetes mellitus, and hypertension. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/3/11, indicated the resident had memory problem and required limited assistance by staff with all activities of daily living (ADLs). A plan of care dated 5/25/11, indicated in the approaches to answer the resident's call light promptly. On 7/5/11, at 2:10 p.m., during an interview, the charge nurse stated nursing staff is to respond to residents' calls as soon as possible. The resident was transferred on 7/1/11, at 3:30 p.m., to an acute care hospital due to intractable	F 353	response and updates monthly and as needed. **Administrator** will follow up findings from the Resident Council meeting monthly and discuss updates and improvements to the daily stand up department managers Meeting monthly. **Administrator** will follow up and discuss findings to the Quality Assurance meeting monthly. **DATE OF CORRECTION 7/7/11**	

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F 353	Continued From page 21 vomiting. 2. On 6/29/11, at 1:30 p.m., during a group interview, Resident 9, with tears in her eyes and visible upset, complained she frequently experienced waiting for extended periods of time before nursing staff responded to her call for assistance with toilet use, only to have that staff member tell her, "Just go ahead and relieve yourself, I will clean you up later". A review of the clinical record revealed the resident was readmitted to the facility on 8/11/10, with diagnoses which included knee joint replacement, hypertension, disc degeneration, and anemia. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 6/22/11, indicated the resident had no memory problem, was incontinent of bowel and bladder functions, required extensive assistance with transfer, locomotion, and toilet use. 3. On 6/29/11, at 1:30 p.m., during a group interview, Resident 4 stated he frequently experienced long waits before nursing staff responded to his call light. The resident indicated the situation was not unusual and most often times happened in the evenings and weekends. A clinical record review indicated the resident was admitted to the facility on 6/14/10, with diagnoses that included schizophrenia, osteoporosis, insomnia, muscle weakness, and hypertension. 4. On 6/29/11 at 1:30 p.m., during a group	F 353		

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F 353	Continued From page 22 interview, Resident 14 stated that in his experience, staff response to call lights has improved and was down to an average of fifteen minutes wait. However, he went on to state that the response time was significantly longer in the past and has been an on going priority concern for the residents council. A clinical record review revealed the resident was readmitted to the facility on 4/2/10, with diagnoses that included convulsions, multiple sclerosis, and neurogenic bladder. The MDS dated 5/8/11, indicated the resident required limited to extensive assistance with transfer, eating and personal hygiene. 5. On 6/29/11 at 1:30 p.m., during a group interview, Resident 26 stated she had experienced waiting for up to an hour before facility staff responded to her call light and long waits were not unusual. She also stated that she had observed another resident's call light that was activated for 30 minutes before any staff member responded. On 7/5/11, at 10:45 a.m., during an individual interview, the resident stated that she has observed her roommate, Resident 18, experiences waiting for up to forty five minutes before staff responded to the call light in their room. The resident further stated there was not enough staff to care for the residents who lived there. A clinical record review revealed the resident was admitted to the facility on 12/11/10 , with diagnoses that included chronic osteomyelitis, hypertension, and atrial fibrillation.	F 353		

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F 353	Continued From page 23 6. On 6/29/11, at 11:30 a.m., during an individual interview in the resident's room, Resident 6 who was alert and oriented, stated that the staff response time to call lights was frequently poor and the facility needed to hire more people. The resident also stated the problem was common during the evening and night shifts, and weekends. A review of the clinical record revealed the resident was admitted to the facility on 5/6/11, with diagnoses that included acute respiratory failure, tracheostomy, end stage renal disease, and hypertension. 7. On 7/5/11, at 10:15 a.m., during an individual interview with Resident 2, who was alert and oriented to person, place, and circumstances, stated he had experienced waiting for up to an hour before staff responded to the call light and that sometimes they did not respond at all. The resident also stated the facility did not have enough help to take care of all the residents. A clinical record review revealed the resident was readmitted to the facility on 6/16/11, with diagnoses that included status post fracture of left leg with cellulitis, coronary artery bypass, diabetes mellitus, morbid obesity, and hypertension. 8. On 7/5/11, at 10:45 a.m., during an individual interview in the residents room, Resident 20 stated few months ago he experienced waiting for up to forty five minutes before staff responded to	F 353		

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F 353	Continued From page 24 the call light. He stated staff have been better and the wait was down to fifteen to thirty minutes. A clinical record review revealed the resident was readmitted to the facility on 6/17/11, with diagnoses that included muscle weakness, acute kidney failure, chronic airway obstruction, hypertension, cerebral artery occlusion, convulsions, and pulmonary embolism. According to the facility's policy and procedure on Call Light, all personnel will respond to resident's requests and needs. Call lights are answered promptly. A review of the Resident Council Meeting Minutes dated 4/11/11, on the page titled Old Business Needing Further Actions, the following note was found under #1: "Call lights - Still a problem - Not to 15 minutes yet". The Resident Council Minutes dated 5/16/11, on the page titled Old Business Needing Further Actions, the following note was found under #1: "Call lights improved to 15-20 but would like us to continue to focus on." The Resident Council Minutes dated 6/13/11, on the page titled Old Business Needing Further Actions, the following note was found under #1: "Call lights - improving, 3-11 mostly now, particularly from 10-11 p.m."	F 353		
F 371 SS=D	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	F 371	FTAG 371 SS = D Walk in refrigerator was cleaned immediately on **6/29/11.** **Dietary Supervisor** checked and inspected other storage areas potential for unsanitary conditions on **6/29/11** and no other similar areas identified and affected.	

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F 371	Continued From page 25 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored, prepared and/or distributed under sanitary conditions by failing to ensure the walk-in refrigerator was maintained in a sanitary condition. The wall and ceiling of the walk-in refrigerator were covered with mold-like substance. This deficient practice had the potential to place the residents at risk for foodborne illnesses. Findings: On 6/29/11, at 2:52 p.m., during the kitchen inspection, the walk-in refrigerator was observed to have a black colored mold-like substance accumulated, four to five feet, on one side of the wall and ceiling of the refrigerator. The rest of the wall in the refrigerator had a light pine-wood color. At the time of the observation, when interviewed, the dietary manager did not know what the growth substance was.	F 371	No residents were affected by the deficient practice identified. **Dietary Supervisor** gave in-service on **6/29/11** regarding appropriate cleaning and inspection of storage areas. **Dietary Supervisor** will do daily visual inspection in all kitchen areas and storage spaces to routinely identify potential unsanitary conditions and report findings to the administrator. **Administrator** will do follow up rounds and visual inspection weekly for compliance and discuss findings to the daily stand up Department Managers meeting. **Administrator** will follow up and discuss findings in the Quality Assurance Meeting monthly. **DATE OF CORRECTION 6/29/11**	6/29/11
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.	F 441	FTAG 441 SS = E **Resident # 21** was discharge on isolation on **7/17/11** with no further signs and symptoms of infection identified. **Resident # 21** room mate did not develop any sign and symptoms of infection and was discharged to home.	

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F 441	Continued From page 26 (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, interview, and record review, the facility failed to implement measures to prevent the development and spread of infection for one of 24 sample residents (21).	F 441	**Director of Nursing and Infection Control Nurse** reviewed and check resident records on **6/29/11** and no other residents were affected by the deficient practice identified. **Director of Nursing and Infection Control Nurse** Initiated in-service on **6/30/11** to CNA'S and Licensed nurses on **7/6/11, 7/14/11 and 7/20/11** respectively regarding Infection control per facility policy and procedures including surveillance and reporting. **Infection Control Nurse** will do random review of resident records weekly for compliance and report findings to the Director of Nursing. **Medical Records will do audit review** on resident records weekly and report findings to the Director of Nursing and Administrator. **Infection Control Nurse** will do follow up in-service on infection control updates and procedures monthly and as needed. **Quality Assurance Nurse** will do random visits and review of records monthly and report findings to the Director of Nursing and Administrator. **Administrator** will do follow up and discuss findings to the Quality Assurance Meeting monthly. **DATE OF CORRECTION 7/20/11**	7/20/11

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F 441	Continued From page 27 Resident 21 who had ESBL (extended-spectrum beta lactamase, a multi-drug resistant infection) in urine, was not placed on contact isolation when the infection was identified and the infection was not investigated. This deficient practice caused delayed interventions and placed other residents at risk of infection. Findings: On 6/29/11, at 1:30 p.m., Resident 21 was observed sitting in a wheelchair and able to communicate her needs. A review of the clinical record revealed the resident was readmitted to the facility on 5/5/11, with diagnoses that included diabetes mellitus, chronic obstructive pulmonary disease, and atrial fibrillation. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/15/11, indicated the resident had no memory problem, required extensive to total assistance with all activities of daily living (ADLs), and was incontinent of bowel and bladder functions. A urinalysis report dated 5/18/11, indicated the urine was cloudy in appearance and had many bacteria. The urine culture dated 5/20/11, indicated the resident was positive for ESBL. The physician ordered the antibiotic Macrobid 100 milligrams (mg) twice a day for five days for urinary tract infection. A physician's order for contact isolation precaution was obtained on 6/6/11, 16 days after the resident was identified with ESBL. A facility's policy and procedure on Antibiotic Resistant Microorganism (ARM) dated 4/1/08,	F 441		

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F 441	Continued From page 28 indicated prevention and control of ARM transmission included to implement standard precautions including contact precautions. A review of the Infection Control Surveillance Information for the month of 5/2011, revealed the form did not list Resident 21's infection. On 7/6/11, at 11:30 a.m., during an interview, the Infection Control Nurse stated she was not aware the resident had ESBL infection in the urine, therefore, she did not identify the resident in the surveillance form. The Infection Control Nurse stated the charge nurse was supposed to inform her regarding the infection, so she could investigate the infection. An undated infection control policy and procedure on Control, Monitoring and Surveillance, indicated to monitor and investigate the cause of infections, infection trends, and implement corrective measures, as needed. The charge nurse will report all infections to the Infection Control Nurse and may use the Resident Infection Control Surveillance Form as a method of informing. The Infection Control Nurse will investigate for infection and record infection data for the monthly infection report.	F 441		
F 456 SS=E	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:	F 456	FTAG 456 SS = E The first floor machine room was immediately cleaned and oxygen tank was placed back to the secured wall mounted area on 7/1/11. All Oxygen identified on the second floor near room 18 oxygen storage closet were secured immediately in racks.	

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F 456	Continued From page 29 Based on observation, interview, and record review, the facility failed to ensure all essential mechanical, electrical, and patient care equipment were maintained in safe operating condition. Flammable and combustible materials stored in the elevator engine/generator room were not safely stored. Three of five oxygen cylinders were not secured in one of two oxygen storage room. This deficient practice may cause or contribute to explosion or fire. Findings: 1. On 7/1/11, at 3 p.m., while with the director of maintenance, the first floor machine room that contained the elevator engine generator, was observed to have a very hot temperature. The machine room had the following: - a fire extinguisher stored on the floor, and not wall mounted. - a five-gallon container, labeled lubricant oil and flammable. The container had a small amount of lubricant liquid. -cardboard boxes stored next to the engine generator. At the time of the observation, when interviewed, the director of maintenance stated that on 7/1/11, staff from the elevator service company left the fire extinguisher, the cardboard boxes, and the oil container on the floor, next to the engine generator. 2. On 7/1/11, at 3:28 p.m., the oxygen storage closet, located on the second floor, near Room 18, was observed to have three of 15 emergency portable oxygen tanks not firmly secured. They easily rocked when touched.	F 456	**Maintenance Supervisor** checked all equipment storage rooms on **7/2/11** and no other areas were identified and affected. No residents were affected by the deficient practice identified . **Maintenance Supervisor** will do daily rounds and visual inspection daily and report findings to the administrator. **Administrator** will do follow up rounds and visual inspection weekly for compliance and report findings to the daily stand up Department Managers Meeting. **Administrator** will follow up and discuss findings to the Quality Assurance Meeting monthly. **DATE OF CORRECTION 7/2/11**	7/2/11

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F 456	Continued From page 30 At the time of the observation, when interviewed, the director of housekeeping services, confirmed the tanks were not secured. On 7/1/11, at 3:33 p.m., when interviewed, a registered nurse supervisor stated the tanks should have been chained or placed in racks.	F 456		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the environment in good repair. There were walls and ceilings in disrepair and a soiled staircase. Findings: 1. On 07/01/11, at 11:10 a.m., the third floor machine room, which contained the hot water boilers was observed with broken walls. The wall had three areas where the wall plasters was open/cracked. In addition, the machine room had an opening in the ceiling to the roof, large enough to allow the entry of rodents. At the time of the observation, when interviewed, the director of housekeeping services stated they had a rodent trap located in the machine room.	F 465	FTAG 465 SS=D The third floor machine room wall was re-plastered and the ceiling to the roof opening was patch and sealed on 7/1/11. The south stair case from the first floor to the roof was cleaned and walls was re-plastered and painted on 7/7/11. **Maintenance Supervisor** will do random visual rounds in all areas in the facility daily to ensure all areas are maintained and report findings to the administrator. **Administrator** will do follow up rounds weekly for compliance. **Administrator** will follow up and discuss findings to the Quality Assurance Meeting monthly. **DATE OF CORRECTION 7/7/11**	7/7/11

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F 465	Continued From page 31 2. On 7/6/11, at 11:40 a.m., the south staircase, one of the two sets staircases located in the facility, from the first floor to the roof levels, the floors and walls were observed with accumulations of dirt. The walls plaster and paint were bulging out from the wall surface. At the time of the observation, the director of maintenance stated he believed the water was entering the walls from the roof, over the staircase.	F 465		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure timeliness of the laboratory service for one of 24 sampled residents (21). Resident 12's order for a laboratory test to rule out an infection was done six days after it was ordered. This deficient practice had the potential for delayed interventions. Findings: A clinical record review revealed Resident 12 was readmitted to the facility on 3/25/11, with the diagnoses that included Clostridium Difficile Infection (C-Diff - a type of bacteria that can cause lower abdominal discomfort, bloating, and loose stools), hypertension, and atrial fibrillation.	F 502	FTAG 502 SS = D **Director of Nursing** initiated in-service to licensed nurses on 6/30/11 regarding logging of laboratory orders per facility policy and procedures. **Director of Nursing and Medical Records Director** checked and reviewed residents laboratory records and no other residents were affected by the deficient practice identified. **RN Supervisor** will review laboratory log daily to ensure all laboratory orders are done and results were in the resident charts . Findings will be reported to the Director of Nursing. **Medical Records Director** will do Audits weekly and report findings to the Director of Nursing and Administrator. **Director of Nursing** will do random record review weekly and report findings to the daily stand up Department Managers Meeting.	6/30/11

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F 502	Continued From page 32 The Minimum Data Set (MDS -standardized assessment and care planning tool dated 4/5/11, indicated the resident had memory problems, was severely impaired for daily decision making, was continent of bowel, and required extensive to total care. The attending physician ordered on 6/23/11, to check the stool for C. Diff. According to the activities of daily living record dated from 6/23/11 to 6/28/11, the resident had bowel movements daily. However, a sample was not obtained for the laboratory test until 6/29/11. On 6/29/11, at 3:10 p.m., during an interview, a licensed vocational nurse (LVN) stated the laboratory test should have been been done when the resident had bowel movements soon after the order was obtained.	F 502	**Administrator** will follow up and discuss findings to the Quality assurance Committee meeting monthly. **DATE OF CORRECTION 6/30/11**	