STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. BUILDING _____ B. WING _____	04/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEA REHABILITATION HEALTHCARE	7716 S PICKERING AVENUE WHITTIER, CA 90602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: [redacted]s, RN, HFEN [redacted], RN, HFEN [redacted], REHS, HFE I Total resident population: 103 Total resident sample: 21	F 000	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged on this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the allegation of compliance.	
F 241 SS=D	Highest Scope and Severity: D 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 promote care to residents in a manner and in an environment that maintains each resident's dignity and respect in full recognition of his or individuality for 2 of 21 sample residents (19, 20). Resident 19 complained that a certified nursing assistant (CNA) during 3-11 shift hid the call light, and did not position the call light within her reach. Resident 20 complained that he had to wait 20	F 241	F 241 **How corrective actions are accomplished:** All staff members have been in-serviced on 4/11/11 on facility Policy and Procedure for Call Lights. Emphasis placed on call lights are to be answered promptly by any staff member. **Identifying residents/area potentially affected:** Resident's requests are to be promptly communicated to appropriate staff member to accommodate the needs of the resident. **Systematic changes to avoid recurrence:** All staff members are educated in keeping the residents call light within the residents	5/11/11

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HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 5/19/2011

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 241	Continued From page 1 minutes for staff to answer his call light during the 11-7 shift to request for pain medication for his headache. This deficient practice has the potential to cause delayed services and not meeting the residents' needs. Findings: 1. During a Quality of Life Assessment Group Interview on 4/6/11, at 10:20 a.m., Resident 19 (1 of 11 residents in the group interview) was observed sitting in a wheelchair, alert, oriented and verbally responsive. The resident complained that on two occasions, a CNA during 3 p.m. to 11 p.m. shift hid the call light and she could not reach it. During another interview with the resident on 4/12/11, at 8:25 a.m., she stated she could not name the CNA, since the CNA was not her regularly assigned staff. The CNA placed the call light in the bedside table drawer. The resident stated she felt uncomfortable when the call light was out of her reach and was not able to call when she needed something during the night. A review of the clinical record revealed Resident 19 was re-admitted to the facility on 2/24/09, with diagnoses of diabetes mellitus, hypertension, rheumatoid arthritis, and history of cerebrovascular accident (stroke) with right side hemiplegia (paralysis of one side of the body). The Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 2/18/11, indicated Resident 19 had no memory problems, required extensive assistance in all activities of daily living, and was frequently incontinent of bowel and bladder.	F 241	reach while in bed and while using the bathroom. Nursing staff also be re-educated on staff assignments for coverage during nurse breaks and lunches. **Monitor so solutions are sustained:** All staff will monitor with visual rounds to insure all call lights are answered promptly. DON, CCC, & DSD will monitor for compliance. All findings will be discussed in monthly CQI meeting.	

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F 241	Continued From page 2 During an interview with the 3 p.m. to 11 p.m. shift Registered Nurse (RN) on 4/11/11, at 3:35 p.m., she stated she made sure that call lights were positioned where residents can reach and call lights were answered promptly. A review of the facility's policy and procedure on Call lights indicated nursing is to assure call lights are within the resident's reach when in his/her room or when on the toilet. 2. On 4/12/11, at 8:25 a.m., Resident 20 was observed awake in bed, alert, and verbally responsive. The resident did not speak English, but using a Licensed Vocational Nurse (LVN) as an interpreted complained to the Evaluator that the nurses did not answer the call lights promptly during the night. The resident stated that during the night shift (11 p.m. to 7 a.m.) he was calling to request a pain pill for his headache and there was delay of 20 minutes. The resident stated he felt bad for not getting his pain medication on time. A review of the Admission and Discharge Summary form (face sheet) indicated Resident 20 was readmitted to the facility on 6/7/10, with diagnoses that included diabetes mellitus, hypertension, chronic kidney disease, seizure disorder, and history of spinal stenosis. The Minimum Data Assessment Set (MDS - standardized assessment and care planning tool) dated 1/20/11, indicated the resident was moderately impaired in cognitive skills with daily decision making and required extensive assistance with activities of daily living. A review of the minutes of the Resident Council	F 241		

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F 241	Continued From page 3 Meetings dated 2/11/11, and 3/11/11, revealed Resident 20 had problems with his call light being removed from the wall. On 4/12/11, at 9:25 a.m., during an interview, the Director of Staff Development (DSD) stated the call lights should be answered promptly within two to three minutes. The facility's policy and procedure on Call Lights indicated staff to monitor the call lights and make sure that call lights are answered promptly, regardless of who is assigned to the resident.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F 279** **How corrective actions are accomplished:** On 4/6/11 when identified by evaluator, Resident #11 Care Plan was updated to include Plan of Care specific for ventilator dependent residents. **Identifying residents/area potentially affected:** All ventilator dependent residents care plans were updated to include the plan of care specific to ventilator care. **Systematic changes to avoid recurrence:** On 4/15/11 all nursing staff members were in-serviced on facility Policy and Procedure on assessment and care planning of ventilator dependent residents. **Monitor so solutions are sustained:** DON, CCC will monitor for all ventilator dependent residents have a plan of care	04/12/11

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to use the results of the assessment to develop a plan of care to ensure the resident's needs are met for 1 of 21 sample residents (11). Resident 11 who was dependent on a ventilator for breathing, had no plan of care addressing interventions to be implemented for proper respiratory treatment and care, and the objectives to be achieved. This deficient practice has the potential for the resident not to receive adequate respiratory care. Findings: On 4/6/11, at 9 a.m., Resident 11 was observed in bed, had a tracheostomy tube connected to a ventilator Breathing machine), receiving feeding through a gastrostomy tube, and intravenous (IV) fluids infusing via a central IV line. A review of the clinical record revealed the resident was admitted to the facility on 3/28/11, with diagnoses that included acute respiratory failure, ventilator dependent, tracheostomy,and chronic airway obstruction. A review of the resident's care plan titled, "Respiratory" dated 3/28/11, did not reflect interventions specific to the resident's needs due to the mechanical ventilation. On 4/6/11, at 2:20 p.m., during an interview with the clinical care coordinator of the Subacute Unit, she stated there should be a care plan for the resident's use of a ventilator. The clinical coordinator further reviewed the clinical record,	F 279	specific to ventilator care and assessment, by audits done by Medical Records to ensure compliance. All findings will be discussed in monthly CQI meeting.	

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F 279	Continued From page 5 and did not find a care plan for the use of the ventilator. A review of the facility's policy and procedure titled, "The Resident Care Plan", indicated for staff to complete data on resident's care plan at the time of admission and that nursing care plan acts as a communication instrument between nurses and other disciplines. The care plan contains information of importance for concerning nursing approach and problem solving.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living, was assisted with personal hygiene and grooming for 1 of 21 sample resident (12). Resident 12's fingernails were not trimmed and cleaned. This deficient practice has a potential for skin breakdown and poor personal hygiene. Findings: A review of Admission and Discharge Summary form indicated Resident 12 was admitted to the facility on 4/14/10, with diagnoses that included chronic dermatitis. The Minimum Data Set (MDS	F 312	**F 312** **How corrective actions are accomplished:** On 4/6/11 upon identification, resident #12 had his fingernails cleaned and trimmed. At that time resident was assessed for any other grooming needs. Resident #12 was also assessed by the Occupational Therapist for the need of a hand roll to prevent the resident's hand of potential breakdown. **Identifying residents/area potentially affected:** All residents were assessed for grooming needs i.e.; fingernail care and the need for any device i.e.; hand roll, heel protector to aid in reducing pressure on areas prone to skin impairment. **Systematic changes to avoid recurrence:** Nursing staff members were in-serviced on ADL and grooming skills on 4/15/11. Nursing staff members were re-educated to include nail care as a part of grooming on a daily basis and as needed.	04/15/11

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F 312	Continued From page 6 - standardized assessment and care planning tool) dated 1/13/11, indicated the resident had no speech and required extensive assistance by staff with personal hygiene. The care plan dated 1/13/11, developed for the resident's problem of self care deficit, included in the approaches to trim the resident's fingernails as needed. On 4/6/11, at 9:20 a.m., the resident's fingernails were observed long with blackish substance underneath. The resident's fingernails were pressing against the skin of the palm of the hand, posing a risk for skin breakdown. On 4/7/11, at 11:30 a.m., during an interview, the certified nursing assistant (CNA) assigned to the resident, stated the resident did not refuse to have his fingernails trimmed.	F 312	**Monitor so solutions are sustained:** Charge Nurse, RN Supervisor, DON, CCC, DSD, will monitor during rounds that residents grooming needs are met, also to monitor appropriate pressure reducing devices are used to reduce pressure on pressure prone areas. Findings will be discussed in monthly CQI meeting.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 315	**F 315** **How corrective actions are accomplished:** At the time of identification, Resident #7 Treatment Administration Record (TAR) was updated to include monitoring resident's urine via urinary drainage bag for signs and symptoms of Urinary Tract Infection every shift. **Identifying residents/area potentially affected:** All residents with a Foley catheter were reviewed to insure proper documentation for Urinary Tract Infection on Treatment Administration Record per Policy and	04/15/11

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F 315	Continued From page 7 review, the facility failed to ensure that a resident with an indwelling catheter receives appropriate treatment a services to prevent urinary tract infection (UTI) for for 1 of 4 residents with urinary catheters out of 21 sample residents (7). Resident 7's characteristics of the urine output was not monitored as stated in the plan of care and physician's order. This deficient practice has the potential for complication from unidentified urinary tract infection (UTI). Findings: On 5/6/11, at 8:50 p.m., Resident 7 was observed to have an indwelling catheter for urinary drainage. According to a review of the clinical record, Resident 7 was readmitted to the facility on 3/11/11, with diagnoses that included ventilator dependent, gastrostomy tube (GT) feeding, and UTI. A care plan dated 3/11/11, was developed for the resident's alteration in urinary elimination with the use of a urinary catheter and the potential risk for infection. The approaches included to monitor for signs and symptoms of UTI such as: increased in mucous, sediment, and change in color of urine. A physician's order dated 3/12/11, indicated to monitor the urinary drainage bag every shift for signs and symptoms of UTI. A physician's order dated 4/2/11, indicated the administration of the antibiotic Levaquin 500 milligram (mg) through the GT daily for seven days, due to elevated temperature.	F 315	Procedure. **Systematic changes to avoid recurrence:** All nursing staff members were in-serviced on 4/15/11 on Policy and Procedure for prevention of Urinary Tract Infection, required documentation in the nurse notes, monitoring of Treatment Administration Record, and importance reporting any signs or symptoms to Physician in a timely manner. **Monitor so solutions are sustained:** DON, CCC and Licensed Nurses will monitor by audits done daily by Medical Records for new orders and Foley catheter audit done on monthly basis. Findings will be discussed in monthly CQI meeting.	

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F 315	Continued From page 8 A urinalysis (urinary laboratory test) dated 4/3/11, indicated the resident's urine had turbid appearance, many bacteria, 2+ occult blood (with a negative reference range) and 1+ protein (with a negative reference range). On 4/6/11, the Levaquin was discontinued and the physician ordered the antibiotics Macrobid 100 mg every 12 hours for seven days and Nitrofurantoin 100 mg four times a day for seven days through the GT for UTI. Further record review and an interview on 4/7/11, at 10:10 a.m. with a licensed nurse supervisor, revealed that during the month of 4/2011, there was no monitoring of the urine characteristic as stated in the plan of care and the physician's order.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident who was fed through a gastrostomy tube (GT) receives appropriate treatment and services to	F 322	***F 322*** **How corrective actions are accomplished:** When identified by the evaluator, the resident's head of the bed was evaluated as ordered, and the LVN repositioned the head of the bed to 30 to 45 degrees. **Identifying residents/area potentially affected:** RN Supervisor and Charge Nurse made room rounds to ensure all residents receiving enteral feeding and Water flush had head of the bed elevated 30 to 45 degrees.	04/15/11

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F 322	Continued From page 9 prevent aspiration pneumonia for 1 of 7 residents with tube feedings in a sample of 21 (12). Resident 12's head of bed was not elevated to a 30 to 45 degree angle while receiving fluids through the GT. This deficient practice create a potential for the resident to have complications from the GT (a tube placed directly into the stomach for long term feeding and administration of medications). Findings: On 4/5/11, at 8:37 a.m., during the initial tour of the facility, Resident 12 was observed lying on his back in bed. The head of bed was slightly elevated while receiving water at 40 milliliter (ml) per hour through the GT. At the time of the observation, the Evaluator summoned a licensed nurse supervisor to check on the resident's positioning. The licensed nurse supervisor stated the resident's head of bed was elevated to a 25 degree angle instead of 30 to 45 degree angle, and proceeded to raise the resident's head of bed. A review of the Admission and Discharge Summary form (face sheet) revealed Resident 12 was admitted to the facility on 4/14/10, with diagnoses that included status post GT insertion and respiratory failure. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 1/13/11, indicated the resident had memory problems and required limited to total assistance with all activities of daily living. The physician's enteral feeding orders dated 4/14/10, indicated aspiration precautions and to elevate the head of bed to a 30-45 degree angle	F 322	**Systematic changes to avoid recurrence:** All nursing staff members were in-serviced on 4/15/11 on Policy and Procedure for residents receiving enteral feeding positioning of head of the bed should be evaluated 30 to 45 degrees during feeding or during water flush. **Monitor so solutions are sustained:** RN supervisor, charge nurse, CCC, DSD and DON will monitor by visual rounds done on an ongoing basis. Findings will be corrected immediately; all findings will be taken to monthly CQI meeting.	

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F 322	Continued From page 10 at all times. A care plan developed 1/13/11, for the resident's GT feedings for nutrition and hydration secondary to dysphagia (difficulty in swallowing), included in the approaches to keep the head of bed elevated to a 30-40 degrees at all times. A Diagnostic Imaging Report (chest x-ray) dated 4/24/10, indicated the resident had a history of slight lower lobe infiltrate.	F 322		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident maintained acceptable parameters of nutritional status for 1 of 21 sample residents (6). Resident 6 had abnormal prealbumin and albumin levels and the Registered Dietician (RD) did not address the abnormal levels. This deficient practice has the potential to result in lack of nutritional interventions to meet the resident's nutritional needs.	F 325	**F 325** **How corrective actions are accomplished:** When identified by the evaluator that resident #6's Pre Albumin was not addressed, the results were immediately called in to MD and an order was obtained to start resident #6 on a protein supplement. **Identifying residents/area potentially affected:** All residents with low Pre Albumin were identified and forwarded to the RD for nutritional consult if necessary. And lab results and orders for supplement as recommended by the RD were reported to resident's MD. **Systematic changes to avoid recurrence:** All staff members were in-serviced on 4/15/11 on reporting abnormal labs to the MD in a timely manner, emphasis placed on documentation of a physician response to abnormal lab or recommendation from RD on abnormal labs. **Monitor so solutions are sustained:**	04/15/11

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F 325	Continued From page 11 Findings: During an observation on 4/7/11, at 8:10 a.m., Resident 6 was in bed, awake, and eating breakfast. The resident who was alert and oriented stated he gets up on a wheelchair every day and goes to physical therapy. A review of the clinical record revealed Resident 6 was admitted to the facility on 3/10/11, with diagnosis that included status post motor vehicular accident (auto vs. pedestrian accident), with multiple traumatic injuries. A review of the Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/23/11, indicated Resident 6 was able to eat without assistance and required extensive assistance with dressing, toilet use, and transfers. According to the weight record, the resident weighed 160 pound upon admission on 3/10/11, and by 3/17/11, the resident's weight was 155 pounds (5 pounds weight loss in one week). A laboratory test result dated 3/14/11, indicated the albumin level was 2.1 gram per deciliter (g/dl) with a reference range from 3.5 to 5.0 g/dl. Another laboratory test result dated 3/14/11, indicated the pre-albumin level was 10.8 milligram/deciliter (mg/dl) with a reference range from 18 to 38.0 mg/dl. On 3/22/11 the pre-albumin level was 12.7 mg/dl. Albumin is the most abundant protein in blood serum. Decreased level of Albumin may indicate severe malnutrition. Prealbumin is a protein produced primary by the liver and decreased	F 325	DON, CCC, DSS, and RD will monitor on an ongoing basis to insure all residents requiring nutritional interventions by daily telephone order audits. Findings will be taken to monthly CQI for discussion at monthly meetings.	

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F 325	Continued From page 12 levels may indicate malnutrition (Lippincott William & Wilkins, Diagnostic Tests Made Incredibly Easy!-2nd edition, 2009, Pages 44-47). A review of the RD notes revealed the RD had two documentation, one on 3/17/11, and the last note dated 3/25/11. The RD did not address the resident's low albumin and prealbumin levels. According to a multidisciplinary progress record dated 3/28/11, the resident would be referred to the RD due to the low prealbumin level of 12.7 mg/dl. However, by 4/11/11, there was no documented evidence the RD evaluated the resident's low prealbumin level. During an interview with the dietary supervisor on 4/11/11,at 4:45 p.m., she stated she did not notify the registered dietician (RD) about the pre-albumin level 12.7 mg/dl. A review of the facility's policy and procedure titled, "Communication to Registered Dietician", indicated that the dietary supervisor will inform the RD any changes in resident's condition for nutritional consultation.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	F 329 **How corrective actions are accomplished:** When identified all residents receiving Antipsychotic medications were reviewed to insure monitoring of TCAP and orthostatic hypotension and specific behaviors in which medication was prescribed. **Identifying residents/area potentially**	04/15/11

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F 329	Continued From page 13 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate monitoring of side effects/adverse reactions of antipsychotic medications for 1 of 21 sample residents (13). Resident 13, who was receiving the antipsychotic Abilify was not monitored for side effects including postural hypotension (a low blood pressure as a result of positional changes), and adverse effects such as tardive dyskinesia, cognitive impairment, akathisia and Parkinsonism (TCAP). The effectiveness of the antipsychotic Abilify and Depakote (anticonvulsant used as mood stabilizer) was not monitored. The resident's behavior manifestation was not documented from 1/2011 to 3/2011. Findings:	F 329	**affected:** All residents receiving Antipsychotic medication were reviewed to insure behaviors, TCAP, orthostatic hypotension are being monitored per Policy and Procedure. **Systematic changes to avoid recurrence:** On 4/15/11 all RNs and LVNs were in-serviced on Policy and Procedure of monitoring residents on Psychotropic medications requiring TCAP and orthostatic hypotension and any adverse reactions. Included in the in-service was the importance of monitoring the behavior of the resident receiving psychotropic medication. **Monitor so solutions are sustained:** Will be monitored by DON, CCC and IDT on an ongoing basis through chart reviews and audits provided by Medical Records. Findings will be taken to monthly CQI meetings to insure compliance.	

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F 329	Continued From page 14 On 4/6/11, at 8:45 a.m., Resident 13 was observed sitting in a wheelchair, wheeling himself. A record review indicated Resident 13's diagnoses included psychosis (severe mental illness in which a person loses touch with reality, experiences unusual perceptions, and holds false beliefs called delusions) and bipolar disorder(mental illness characterized by mood swings). The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 2/3/11, indicated the resident was able to communicate and required limited assistance by staff with transfer and walking. A physician's order dated 2/25/10, indicated Abilify 2 milligram (mg) orally every night for psychosis manifested by paranoid, grandiose delusional ideas and statements. The order also indicated to monitor the behaviors and any adverse reactions every shift. The Abilify was discontinued on March 9, 2011. An order dated 6/17/10, indicated Depakote ER (extended release) 1000 mg orally at night time for psychosis manifested by sexually inappropriate behavior. On 4/7/11, at 11:50 a.m., during an interview, the director of nursing stated the nurses are to monitor and document every shift presence of adverse reactions (TCAP) from the use of Abilify. Tardive dyskinesia is a neurologic syndrome marked by slow, rhythmical automatic stereotyped movement. Akathisia is a distressing feeling of internal restlessness that may appear as constant motion, inability to sit still, fidgeting, pacing, or rocking. Parkinsonism like symptoms includes tremors, shuffling gait, slowness of movement, expressionless face, drooling,	F 329		

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F 329	Continued From page 15 postural steadiness and rigidity of muscles in the limbs, neck and trunk. The presence of the above adverse reactions (known as TCAP) were to be documented in the medication administration record every shift. The DON also stated the postural hypotension had to be monitored daily for two weeks, then weekly, by taking the blood pressure in sitting and standing position. Further record review revealed there was no documented evidence the nurses monitored the resident for TCAP and orthostatic hypotension from the use of Abilify from 1/1/11 to 3/9/11, when the Abilify was discontinued. It was also noted that from 1/1/11 to 3/9/11, there was no documentation of the nurses were monitoring the resident's behavior manifestation (paranoid, grandiose delusional ideas and statements) to determine effectiveness of the Abilify. In addition, there was no documentation from 1/1/11 to 3/31/11, the nurses were monitoring the resident's sexually inappropriate behavior for which he was receiving Depakote.	F 329		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide assistance in proper use of a special eating equipment for 1 of 21 sample residents (3). Resident 3 was observed eating lunch with a plate guard	F 369	**F 369** **How corrective actions are accomplished:** When it was identified by the evaluator, resident #3's plate guard was immediately adjusted by the nurse to the proper placement to enable the resident to feed independently. **Identifying residents/area potentially affected:** All residents using assistive devices for meals where reviewed to insure proper	04/11/11

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F 369	Continued From page 16 positioned away from the resident impeding scooping of food. This deficient practice has the potential to affect the resident's ability to eat independently. Findings: On 4/6/11, at 12:30 p.m., and on 4/7/11, at 12:40 p.m., Resident 3 was observed sitting on her bed, eating her lunch. The main dish had a plate guard which was positioned away from the resident. The resident had difficulty scooping food to the spoon and keeping the food on the plate. There was no staff assisting the resident with proper positioning of the plate guard. A review of Resident 3's admission record indicated she was admitted to the facility on 5/24/10, with diagnoses that included multiple sclerosis, and diabetes mellitus. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 1/5/11, indicated the resident had short and long-term memory problems, and required extensive assistance with eating. A physician's order dated 3/3/11, indicated the use of a plate guard during meals to prevent food spilling off the plate. On 4/11/11, at 12:30 p.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated plate guards were used to prevent the residents with impaired coordination from spilling food off their plates, and to accommodate the resident's scooping motion.	F 369	placement and usage of device to enable independent feeding. **Systematic changes to avoid recurrence:** All nursing staff members were in-serviced on 4/11/11 by Occupational Therapist, on using assistive devices to enable resident independence with feeding. Nursing staff members were also reminded to check all assistive devices for proper positioning when setting up trays while serving residents meals. **Monitor so solutions are sustained:** Charge nurses, RN supervisors, CCC, DSD and DON will monitor by daily rounds during meal time. Findings will be discussed in monthly CQI meetings.	

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F 369	Continued From page 17 On 4/11/11, at 1 p.m., during an interview, a restorative nurse assistant (RNA) stated all plate guards must be positioned towards but not away from the resident when placed on their plates to aid them in keeping food on their plates and for easier scooping.	F 369		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a drug regimen must be reviewed at least once a month and to report to the attending physician any irregularities for 1 of 21 sample residents (18). Resident 18's multiple use of anti-tuberculosis medications was not brought to the physician's attention from 11/2010 to 2/2011. This deficient practice has the potential for medication irregularities. Findings: A review of Resident 18's admission record indicated an admission to the facility dated	F 428	**F 428** **How corrective actions are accomplished:** Not Applicable **Identifying residents/area potentially affected:** All other residents receiving Anti-Tuberculosis medication were reviewed by the pharmacist and recommendations were communicated to Los Angeles Public Health Nurse and Physician. **Systematic changes to avoid recurrence:** We continue to keep Los Angeles County Public Health informed of residents receiving Anti-Tuberculosis medications regularly and when discharged. **Monitor so solutions are sustained:** DON, CCC and pharmacist will review on ongoing basis residents that receive Anti-Tuberculosis medications and inform pharmacist for review and recommendations to Los Angeles County Public Health Department and Physician on a monthly basis. All findings will be reported to Los Angeles County Public Health Department and CQI monthly.	04/11/11

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F 428	Continued From page 18 11/2/10, with diagnoses of pleural effusion, generalized weakness, dysphagia (difficulty swallowing), and gastrostomy tube (GT). The Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 11/12/10, indicated Resident 18 had no memory problems, had modified independence in cognitive skills for daily decision-making, and was totally dependent on staff for activities of daily living (ADLs). Since admission, on 11/2/10, the physician ordered Pyrazinamide 1,500 milligrams (mg) daily, Rifampin 600 mg daily, Isoniazid 300 mg daily, Ethambutol HCL 1,200 mg daily, and Pyridoxine 50 mg, all five medications to be administered through the GT. On 4/18/11, at 10:45 a.m., during an interview, the infection control nurse stated the above medications were given as anti-tuberculosis (TB) treatment. The infection control nurse also stated all the sputum smears (cultures) and chest x-rays done from admission were all negative, but did not know the reason the resident was still on anti-TB medications. On 4/18/11, at 11:15 a.m., during an interview, the pharmacist consultant stated, Resident 18 should not use five anti-TB medications at the same time, but it was the physician's decision to treat the resident conservatively. However, there was no documentation, the pharmacist brought to the attention of the attending physician, the concern related to multiple anti-TB medication use from 11/2010 to 2/2011.	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=D	Continued From page 19 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. 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:	F 431	**F 431** **How corrective actions are accomplished:** A. When temperature of 30 degrees was identified by the evaluator, the refrigerator was placed on defrost mode. Refrigerator since has been replaced on 4/12/11. Refrigerator temperature in all medication refrigerators was checked to insure a temperature of 36 – 46 degrees. B. Narcotic count sheets on each medication cart were checked to insure signatures of 2 licensed nurses were present to reconcile narcotics at shift change. C. When it was identified by the evaluator that medication needed to be destroyed medications were logged, counted and placed in a medical waste container by 2 licensed nurses. **Identifying residents/area potentially affected:** The medication room in the other unit was checked for medications that need to be destroyed. **Systematic changes to avoid recurrence:** On 4/16/11 an in-service was given to all licensed nurses on medication storage, drug destruction, drug reconciliation of narcotics. Nurses were re educated to policy and procedure on medication destruction and storage, i.e.; refrigerated medications to be kept at 36 to 46 degrees, refrigerator temperature logs to be done daily and actions taken when refrigerator is not within required parameters, daily signing of 2	04/16/11

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F 431	Continued From page 20 Based on observation, interview, and record review, the facility failed to ensure that one of the two medication rooms (Nurse's Station 1) had medications stored in the refrigerator with temperatures between 36 to 46 degrees Fahrenheit (F); failed to ensure accurate account of Schedule II drugs; failed to ensure safe storage and handling of discontinued medications. Findings: a. On 4/7/11, at 9:30 a.m., during the inspection of the medication storage room in Nurse's Station 1 with Licensed Vocational Nurse 2 (LVN 2), the temperature of the refrigerator was 30 degrees F, and had thick ice on the freezer section. At 11 a.m., during a subsequent observation, the same refrigerator as a temperature of 32 degrees F. The refrigerator contained 10 vials of insulin, six boxes of Biscolax suppositories, one vial of Purified Protein Derivative (PPD) injection, six unopened vials of Procrit 3,000 units, and two insulin emergency kits. On 4/11/11, at 9:30 a.m., during an interview, LVN 2 stated she did not know why the facility's medication refrigerator in Station 1 had a temperature below 36 degrees F. She further stated that temperature monitoring should be done and recorded everyday in the Refrigerator Temperature Log. On 4/11/11, at 11 a.m., during an interview, the director of nursing (DON) stated the proper refrigerator temperature was between 36 to 46 degrees F to preserve the integrity, potency and efficacy of the medications.	F 431	licensed nurses for reconciliation of narcotics daily during shift change. Policy and procedure on narcotic reconciliation on a shift to shift time frame and must be signed by 2 licensed nurses. **Monitor so solutions are sustained:** DON, CCC, DSD, RN supervisor will monitor by daily rounds to check temperature logs for completion and to insure refrigerator temperature within required parameters. Medical records will audit every week, findings will be discussed at CQI monthly meeting.	

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F 431	Continued From page 21 A review of Station 1's Refrigerator Temperature Log, indicated a temperature reading of 30 degrees F on 4/5/11, and on 4/6/11. There was no documented temperature from 4/7/11 to 4/9/11. A review of the facility's undated policy and procedure, titled "Drug Storage and Labeling" indicated that drugs stored under refrigeration will be stored between 36 degrees Fahrenheit to 46 degrees Fahrenheit. b. A review of the facility's undated policy and procedure, titled "Medication Security System" indicated that Schedule II Drugs (drugs that have a valid medical use, but are highly habit forming) must have a proof of narcotic count by signatures of licensed nurses on the change of shift, and records must be complete. On 4/6/11, at 9:30 a.m., during the medication storage inspection with LVN 4, it was observed that the Narcotic Check Sheet used by the nurses for narcotic count at the change of shifts, was incomplete on 14 days during the year 2011, lacking proof of narcotic count. There were missing signatures of the nurses changing shifts on 1/12/11, 1/18/11, 1/19/11, 1/21/11, 1/22/11, 2/10/11, 2/16/11, 2/23/11, 3/2/11, 3/3/11, 3/13/11, 3/19/11, 3/25/11, and 3/31/11. On 4/11/11, at 9:45 a.m., during an interview, LVN 2 stated narcotic count must be done by two licensed nurses on the change of shift, must have a proof signatures, and records must be complete.	F 431		

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F 431	Continued From page 22 c. According to the facility's undated policy and procedure, titled "Drug Disposition" indicated that discontinued and outdated drugs that cannot be returned to the pharmacy for credit are to be properly marked and disposed of in accordance with the California's Medical Waste Management Act and documentation of the drugs is to be maintained. The policy further indicated the drug container is to be flagged with a "Discontinued Drug Sticker", a "Not in Current Use" sticker or similar, as well as the date the drug was discontinued. Once the container is ready for pick up by the licensed pharmaceutical waste service, the container must be securely taped, closed, or a tamper-proof tape may be used for additional security, if deemed necessary. On 4/11/11, at 9 a.m., during a medication storage inspection with LVN 4, it was observed that the medication room contained four large boxes and one cabinet filled with different discontinued medications which were not labeled and there was no documentation of the discontinued drugs. The drugs were not in a securely taped and closed container. On 4/11/11, at 9:35 a.m., during an interview, LVN 2 stated that discharged medications must have a log with medication names, their quantities, and are to be kept and maintained at the facility's storage room to ensure proper reconciliation of all doses. She further stated she did not know why the medications were stored in the medication room.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 23 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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.	F 441	**F 441** **How corrective actions are accomplished:** Immediately after being informed of the lack of following the infection control policy and procedures of the facility, the Director of Nursing and the Director of Staff Development, in serviced and educated all licensed nurses on proper infection control policy and procedures. The medication nurse was individually in serviced by the Director of Nursing on proper hand washing techniques. **Identifying residents/area potentially affected:** All staff members observed to insure proper procedures for infection control are administered. **Systematic changes to avoid recurrence:** All staff members were in-serviced on infection control on 4/15/11. Hand washing – emphasis placed on staff must wash their hands after each direct contact resident including during medication administration to prevent spread of infection. **Monitor so solutions are sustained:** Administrator, DON, CCC, DSD, RN supervisor, charge nurses and IDT will monitor all staff members having direct resident contact. All findings suggestions will be discussed in CQI monthly meetings.	04/15/11

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	055764	A. BUILDING _____ B. WING _____	04/12/2011

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F 441	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure implementation of infection control policies to help prevent the development and transmission of diseases and infection for 1 of 21 sample residents (16). Licensed Vocational Nurse 3 (LVN 3) failed to change gloves and wash her hands before and after giving eye drops medication to Resident 16. Findings: On 4/6/11, at 9 a.m., during the medication pass observation, LVN 3 was observed preparing and administering Resident 16's oral medications wearing disposable gloves. LVN 3 picked up a box of tissue paper from the floor, and was about to administer the resident eye drops (Timolol 0.5% Ophthalmic Solution) without removing the soiled gloves and without washing her hands prior to giving the medication, when the Evaluator intervened. LVN 3 stated she should have changed gloves or wash her hands before giving the eye drops to Resident 16 to prevent cross contamination. A review of the admission sheet revealed Resident 16 was admitted to the facility on 9/30/10, with diagnoses that included congestive heart failure, pleural effusion, and hypertension A physician's order dated 9/30/10, indicated Timolol 0.5% Ophthalmic Solution one drop to both eyes daily. A review of the facility's undated policy and	F 441		

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F 441	Continued From page 25 procedure titled "Administration of Eye Drops" indicated that all staff members were to wash their hands thoroughly.	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide at least 80 square feet per resident. Findings include: Rooms 14, 15, and 18 accommodate two residents. Rooms 5, 6, 8, 9, 11, and 12 accommodate three residents. Rooms 16 and 17 accommodate four residents. The space available for the residents is sufficient to provide access and freedom of movement. ROOMS SQUARE FEET 5 204.30 6 208.15 8 204.50 9 201.40 11 201.40 12 201.40 14 151.20 15 151.20 16 278.48 17 278.48	F 458	**F 458** **How corrective actions are accomplished:** A letter to request a waiver was submitted on April 12, 2011 for the rooms 5, 6, 8, 9, 11, 12, 14, 15, 16, 17, and 18 for approval. **Identifying residents/area potentially affected:** Facility will insure proper space is provided to the residents, and will insure that resident privacy and dignity are maintained. **Systematic changes to avoid recurrence:** Administrator will monitor for compliance and report any issues or concerns with the CQI members at the facility monthly CQI meeting. **Monitor so solutions are sustained:** Monitoring will be on an ongoing basis to insure facility compliance.	04/12/11

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F 458	Continued From page 26 18 151.20	F 458		
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 provide a safe and sanitary environment by having excessive amount of lint in the lint compartment to the dryers, and by having an accumulation of melted items on the drums to the dryers. This deficient practice poses a risk for fire. Findings: On 4/5/11, at 9 a.m., during the general observation of the facility tour, in the presence of the maintenance supervisor, it was observed that the lint compartment to the dryers had an accumulation of lint on the screen and on the floor of the compartment. The drums to the dryers were observed with an accumulation of melted items stuck to the drums. On 4/5/11, at 9:15 a.m., during an interview with a laundry staff member, she said that she cleaned the lint traps at 6 a.m.. She also said that the drums to the dryers are wiped down daily. A facility policy was requested at this time. On 4/8/11, at 10 a.m., during an interview, the maintenance supervisor stated the dryer drums	F 465	**F 465** **How corrective actions are accomplished:** The accumulation of lint in the dryers and the identified melted items in the dryers have all been cleaned and cleared of debris. **Identifying residents/area potentially affected:** All dryers and dryer drums have been inspected to be cleared of melted-on items and free of accumulated lint. **Systematic changes to avoid recurrence:** All housekeeping and laundry staff have been in-serviced on maintaining dryers free of lint and melted materials. **Monitor so solutions are sustained:** Maintenance supervisor and his designee monitor by direct observation on a weekly basis all laundry machinery for cleanliness and functionality. Any problems will be brought to the attention of the Administrator, who will become involved in resolving the problem. This plan of correction has been integrated into the quality assurance system, and is reviewed quarterly by the quality assurance committee for its effectiveness and to insure compliance.	04/12/11

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F 465	Continued From page 27 with melted on items will be replaced with new ones, and the old drums will be cleaned and saved for future use. By 4/12/11, the facility did not produce a policy and procedure on maintaining the dryers free from accumulation of lint.	F 465		
F 467 SS=B	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation , interview, and record review the facility failed to provide adequate ventilations to bathrooms in resident Rooms 6, 18, 25, 27, 30, 35, and 39, and the Subacute Unit Shower Room 4. There was no negative air flow when tested. Findings: On 4/5/11, at 10:30 a.m., during the general observation of the facility tour, in the presence of the maintenance supervisor, Rooms 6, 18, 25, 27, 30, and 39, and the Subacute Unit Shower Room 4 had no negative air flow. The exhaust vents in the bathrooms to these rooms were tested with a piece of tissue, and were unable to hold the tissue to the vent. On 4/5/11, at 12 p.m., during an interview, the maintenance supervisor stated some rooms in the older part of the facility had individual exhaust	F 467	**F 467** **How corrective actions are accomplished:** The ventilation system in rooms 6, 18, 25, 27, 30, 39, and the sub acute shower room 4, all have been re wired and are all functional to produce a negative air flow. **Identifying residents/area potentially affected:** All ventilation systems throughout the facility have been inspected to be functional and operational to produce a negative air flow. **Systematic changes to avoid recurrence:** All maintenance staff has been in-serviced on checking for operational functionally on a monthly basis. **Monitor so solutions are sustained:** Maintenance supervisor and his designee monitor by direct observation on a monthly basis all bathrooms and ventilation systems for operational functionality. Any problems will be brought to the attention of the Administrator, who will become involved in resolving the problem. This plan of correction has been integrated into the	04/12/11

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F 467	Continued From page 28 motors, which could be the problem. However he was unable to provide explanation for the lack of negative flow in the bathrooms located in the new section of the facility. On 4/5/11, a review of the facility's policy on Ventilation, revealed that a daily check of all ventilation systems is to be done to verify air circulates freely through the facility. The policy also indicated to do monthly check of all fans to verify that they are in good operating condition and to replace as necessary. On 4/6/11, at 10:30 a.m., during another interview, the maintenance supervisor stated he checks the ventilation system daily and monthly, however, he did not have documentation of the daily and monthly checks.	F 467	quality assurance system, and is reviewed quarterly by the quality assurance committee for its effectiveness and to insure compliance.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	**F 514** **How corrective actions are accomplished:** Upon identification, Resident #13 medication administration record (MAR) was addressed to prevent medication administration signed in error. All medication administration records (MAR) were reviewed to identify any discontinued medications not marked as discontinued. When identified by evaluator, Resident #7 order for Ferrous Sulfate was corrected. MD was notified and appropriate dosage was ordered and medication administration (MAR) was corrected to reflect corrected dosage.	04/15/11

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F 514	Continued From page 29 Based on interview and record review, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 21 sample residents (1, 7, and 13). Resident 1's medication administration record did not reflect the time of administration of Tylenol and Vicodin. For Resident 13, the licensed nurses documented the administration of Abilify after it was discontinued. For Resident 7, the dosage of Ferrous Sulfate was wrongly documented in the medication administration record (MAR). This deficient practice had a potential for medication error. Findings: a. According to the physician's dated 8/6/10, Resident 1 was to receive Tylenol 650 milligrams (mg) orally every four hours as needed (PRN) for mild pain. Another physician's order dated 4/3/11, indicated for the resident to have Vicodin 500 mg po every 6 hours PRN for pain. On 4/11/11, at 10 a.m., during a review of the MAR revealed Tylenol 650 milligrams (mg) was given 4/5/11, and Vicodin 500 mg was given on 4/8/11, and on 4/11/11, but the time the medications were given was not documented. On 4/11/11, at 10:20 a.m., during an interview, Licensed Vocational Nurse 2 (LVN 2) stated that the date and time of medication administration should be written specifically in the MAR to prevent medication errors. A review of the facility's undated policy and	F 514	**Identifying residents/area potentially affected:** For all other residents receiving Ferrous Sulfate, MD was notified and appropriate orders obtained to reflect corrected dosages. All orders were transcribed to medication administration record (MAR) to insure residents are receiving the correct dosage. **Systematic changes to avoid recurrence:** All licensed nurses were in-serviced on 4/15/11 on medication dosage calculations and administration. Emphasis was placed accurate transcription of MD orders to medication administration records when order received and on monthly recap of orders. **Monitor so solutions are sustained:** DON, CCC will monitor daily for compliance by daily audits of telephone orders and monthly recap reports done by Medical Record Department. All findings will by taken to monthly CQI for discussion and recommendations.	

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F 514	Continued From page 30	F 514		

procedure titled "Medication Administration" indicated PRN drug administration requires the date and time of administration, dose, and route of administration.

b. A record review indicated Resident 13's diagnoses included psychosis. A physician's order dated 2/25/10, indicated to give Abilify 2 milligram (mg) by mouth every night. The Abilify was discontinued on 3/9/11.
However, a record review and interview with the Director of Nursing (DON) on 4/7/11, at 11:50 a.m. revealed the MAR for the month of 4/2011, still included the order for Abilify, and the licensed nurses were signing from 4/11 to 4/6/11, the medication was administered every night. The DON stated the nurses did not give the medications but erroneously signed the administration of the medication.

c. A review of the admission record revealed Resident 7 was readmitted to the facility on 3/11/11, with diagnoses that included anemia and ventilator dependent.

A review of the recapitulated physician's order dated March 11, 2011, indicated Ferrous Sulfate 300 mg/5 milliliters (ml) through the gastrostomy tube (GT) everyday for supplement.

On 4/6/11, at 9:55 a.m., during a medication pass observation, the medication nurse gave Ferrous Sulfate 7.5 ml of Ferrous Sulfate liquid through the gastrostomy tube, instead of 5 ml.

The MAR for the month of 4/2011, indicated

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F 514	Continued From page 31 Ferrous Sulfate 300 mg/7.5 ml, instead of the recapitulated order for Ferrous Sulfate 300 mg/5 ml. On 4/7/11, at 5:30 p.m., further record review and interview with the DON, revealed the physician's order on readmission dated 3/3/11, was for Ferrous Sulfate 325 mg/7.5 ml. The DON stated the nurse who transcribed the order made a mistake.	F 514		