STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	04/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTROSE HEALTHCARE CENTER	2123 VERDUGO BLVD. MONTROSE, CA 91020

(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 and Complaint Survey. Complaint Number: CA00305453 Unsubstantiated Representing the Department of Public Health: [redacted], HFE-II [redacted], RN, HFEN Total Population: 51 Sample Size: 13 Highest S/S= F	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that an informed consent was obtained prior to the administration of antidepressant medications to two of 13 sampled residents (3 and 10). Findings: a. A review of Resident 3's medical record	F 155		

2012 MAY 14 AM 11:53
LOS ANGELES COUNTY
DEPARTMENT OF PUBLIC HEALTH
LICENSING & CERTIFICATION
DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: N. Revain | TITLE: Administrator | (X6) DATE: 5/11/12

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

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F 155	Continued From page 1 indicated the resident was admitted to the facility on September 6, 2011 with diagnoses that included [redacted]. On March 30, 2012, the physician ordered Effexor 37.5 mg via gastrostomy tube every other day for depression. A review of the medication administration record (MAR) for the month of April 2012, indicated the resident received Effexor 37.5 mg as ordered by the physician. On April 22, 2012, at 12 noon, during an interview with the DON while reviewing the medical record revealed there was no informed consent obtained form the responsible party prior to administration of said medication. b. A review of Resident 10's medical record indicated the resident was admitted to the facility on December 6, 2011, with diagnoses that included [redacted]. On April 2, 2012, the physician ordered [redacted] 10 mg daily for [redacted] A review of the MAR for the month of April 2012, revealed the resident received [redacted] HCL 10 mg daily for [redacted] as ordered. There was an Informed Consent for Fluoxetine signed by the physician but was not dated. The consent failed to document as to whom the consent was obtained (the name of the resident's representative was blank). [redacted] and Effexor are medications used in the treatment of major [redacted] and there	F 155	F155 Resident 3 and 10 informed consent was completed , signed , and dated on 4/12/12 All charts for resident on psychotropic drugs were reviewed by D.O.N. for completion of informed consent All charge nurses were inserviced to obtain informed consent by D.O.N. on 4/24/12 Medical Records will audit for compliance monthly D.O.N. will audit monthly for compliance Overall compliance will be monitored quarterly by QA Committee	5/24/12

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F 155	Continued From page 2 was no consent obtained from Residents 3 and 10 or their representatives.	F 155		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility staff failed to ensure that the	F 278		

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F 278	Continued From page 3 assessment accurately reflected the residents status for three of 13 sampled residents (2, 4, 9). Findings: a. On April 20, 2012, at 7:30 p.m., during the initial tour, Resident 2 was observed lying in bed. The bilateral lower extremities revealed limitation in range of motion. A review of the Minimum Data Set (MDS) assessment dated February 15, 2012, indicated the resident's functional limitation in range of motion (ROM) was coded as 0/2 meaning no impairment on the upper extremity (shoulder, elbow, wrist, hand) and impairment on both sides of the lower extremity (hip, knee, ankle, foot). A review of the Rehabilitation Screening dated February 6, 2012, indicated the resident's ROM was coded as 1/2 meaning impairment on one side on the upper extremity (shoulder, elbow, wrist, hand) and impairment on both sides of the lower extremity (hip, knee, ankle, foot). The Joint Mobility Assessment dated February 14, 2012, indicated the resident's ROM was coded as 2/1 meaning impairment on both sides on the upper extremity and impairment on one side of the lower extremity. b. On April 20, 2012, at 7 p.m., during the initial tour, Resident 4 was observed in bed with right hand flexed on the chest and fist tightly closed. On April 22, 2012, at 9:45 a.m., RNA 1 was observed applying right hand wrist orthosis and right foot orthosis.	F 278	F 278 Resident 2,4,9, and 10 were reassessed by MDS, nursing and rehab immediately MDS nurse to coordinate with Rehab Director any observed changes in active and passive range of motion on a daily basis Charge nurses, MDS and Rehab were inserviced by D.O.N. on 04/23/12 regarding accurate assessments MDS consultant inserviced charge nurses, MDS and Rehab on accuracy of assessment documentation on 4/23/12 MDS consultant will audit monthly on documentation of assessment accuracy monthly Overall compliance will be monitored quarterly by QA Committee	4/23/12

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F 278	Continued From page 4 A review of the MDS dated March 27, 2012, indicated the resident's functional limitation ROM was coded as 1/1 meaning impairment on one side for both upper and lower extremities. The Rehabilitation Screening dated March 11, 2012, indicated the resident's ROM was coded as 1/0 meaning impairment on one side of the upper extremity and no impairment on the lower extremity. The Joint Mobility Assessment dated March 27, 2012, assessed the resident's ROM was coded as having 2/1 meaning impairment on both sides of the upper extremity and impairment on one side of the lower extremity. c. On April 21, 2012 at 3 p.m., Resident 9 was observed ambulating with a use of a front wheel walker in and around the facility. A review of the MDS dated January 2, 2012, assessed the resident's functional status as follows: 1. Transfer: coded as 2/2 meaning limited assistance /one person assist. 2. Ambulation: coded as 2/2 meaning limited assistance /one person assist. 3. Dressing: coded as 2/2 meaning limited assistance /one person assist. 4. Eating: coded as 1/1 meaning supervision/set-up	F 278		

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F 278	Continued From page 5 The licensed nurses weekly summary dated April 16, 2012 and April 23, 2012, however, documented the resident required limited assistance on the areas of sit to stand transfer, ambulation, dressing and supervision on eating. The certified nursing assistant ADL Sheet for the month of April 2012, documented the resident eat by self and ambulatory. On April 23, 2012, at 2:15 p.m., in interview with Certified Nursing Assistant (CNA) 1, she stated the resident do his activities of daily living himself except shower. The DON stated the resident is independent on his activities of daily living. The resident when asked stated he basically do his activities of daily living himself. d. A review of Resident 10's MDS assessment dated January 6, 2012, indicated the resident's Bladder/Bowel was coded as 1/1 meaning occasionally incontinent of both bladder and bowel. On April 23, 2012, at 10:30 a.m., during an interview with the resident she stated that she could feel when she need to urinate and move her bowel. In the daytime she does not use a diaper and able to wheel herself to the bathroom. At night time she wore a diaper because she did not want to have an accident. However, she used the call light at night to be assisted to the bathroom. A review of the certified nursing assistant activities of daily living sheet documented the resident as incontinent of both bladder and bowel. The licensed nurses record	F 278		

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F 278	Continued From page 6 documentation for both bladder and bowel elimination was that the resident as continent.	F 278		
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). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan for a resident who had a pacemaker and to ensure that the care plan included approaches pertinent to the residents needs (6) for one of 13 sampled residents. Findings:	F 279		

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F 279	Continued From page 7 a1. A review of the medical record indicated Resident 6 was initially admitted to the facility on March 19, 2012, and re-admitted on April 12, 2012, with diagnoses that included pneumonia, dysphagia, muscle weakness, gastrostomy tube, and status post pacemaker placement. The Minimum Data Set (MDS) assessment dated March 31, 2012, indicated the resident had no memory problem, independent in cognitive skills for decision making, and needed limited to extensive assistance in activities of daily living. A review of the previous admission indicated the resident has a pacemaker. However, there was no care plan in the active record regarding the use of a pacemaker. On April 22, 2012 at 11:00 a.m., in an interview and record review with Registered Nurse (RN) 1, she stated that the resident has a pacemaker and confirmed that there was no care plan in the chart. a2. During the tour of the facility on April 20, 2012 at 7:00 p.m., Resident 6 was observed in bed and was noted to have skin discoloration and blisters. A review of the care plan dated April 12, 2012, indicated a problem of skin blisters on the left arm and elbow. The approaches however, indicated to apply of heel protectors at all times, to elevate feet with pillows, and to place a pillow in between the legs when on one side. The approaches in the plan of care were not appropriate since the affected body part was the left arm and not the heels and feet.	F 279	F279 A plan of care was developed for Resident 6 regarding use of a pacemaker by D.O.N. on 4/22/12 All charge nurse nurses were inserviced by D.O.N. to careplan residents conditions and to document appropriate approaches to the problem on 4/23/12 Medical Records will audit monthly for compliance D.O.N. will audit random charts for compliance monthly Overall compliance will be monitored quarterly by QA Committee	4/23/12

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F 279	Continued From page 8 On April 22, 2012 at 3:00 p.m., during the record review and interview with RN 1, she stated the approaches were not appropriate for the problem. On April 23, 2012 at 11:00 a.m., after showing the care plan for the blister and the approaches to the director of nurses, he stated that he will inservice the staff to develop appropriate approaches to the problem.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure that a calendar was developed to indicate a schedule to provide a coordinated care and to identify when the hospice personnel will visit the resident to provide the necessary care and services for one of two hospice residents (7), and failed to follow physician order to keep the surgical site open to air after providing treatment (5) for two out of a sampled residents (5,7). Findings: a. During the tour of the facility on April 20, 2012 at 7:30 p.m., Resident 7 was observed in bed	F 309		

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F 309	Continued From page 9 with gastrostomy tube feeding. A review of the medical record indicated Resident 7 was readmitted to the facility on March 30, 2012, with the diagnoses that included diabetes mellitus, hypertension, seizure disorder, gastrostomy tube feeding and under hospice care. A review of the Minimum Data Set (MDS) assessment dated April 11, 2012, indicated the resident was [redacted], was totally dependent on staff for activities of daily living, and was on feeding tube. A review of the hospice records revealed there was no calendar to indicate the scheduled visit of the hospice staff so that the care could be coordinated with the facility staff. On April 23, 2012 at 11:35 a.m., during the record review and interview with the hospice staff, they confirmed that there was no calendar in the chart. They further stated that they will fax the calendar to the facility. b. During the course of the survey days from April 20, 2012 through April 22, 2012, at various times, Resident 5 was observed wheeling himself in and around the facility. There was a dry dressing taped on the resident's right knee. On April 22, 2012, at 11 a.m., the treatment nurse stated she did the treatment of normal saline on the right knee surgical wound and covered it with dry dressing.	F 309	F309 A calendar of scheduled visits by Hospice for Resident 7 was completed immediately and placed in the chart Social Services will coordinate with Hospice Agency during monthly IDT meetings Hospice Agency was contacted by Administrator to comply with requirements of the services on 4/23/12 Medical Records will audit monthly for compliance Overall compliance will be monitored quarterly by QA Committee	4/23/12

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F 309	Continued From page 10 During a concurrent interview of the record with the treatment nurse the medical record indicated a physician order dated April 10, 2012, to cleanse the right knee arthroplasty incision with normal saline, apply Polysporin Ointment and leave open to air for 30 days. A review of the Treatment Record for the month of April 2012, indicated that the treatment was consistently being done, however, the physician order to leave the wound open to air was not implemented.	F 309	F 309 Residents 5 dressing was removed immediately and left open to air as ordered Treatment nurses was inserviced immediately by D.O.N. on 4/22/12 following doctors orders	4/22/12
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 staff failed to ensure a excess linen would not be placed over the resident's low air loss mattress (LAM) and caused the potential to compromise the pressure relieving effect of the LAM, a delay to promote healing of pressure sores and prevent the development of new pressure sores for one of 13 sampled residents (1).	F 314	D.O.N. will review treatment orders weekly and monitor for compliance Overall compliance will be monitored Quarterly by QA Committee	

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F 314	Continued From page 11 Findings: According to the Admission and Discharge Summary, Resident 1 was admitted to the facility on December 6, 2011, with diagnoses that included [redacted] hypertension, left lower leg contracture, and pressure ulcer. The admission assessment documented the resident had a Stage IV pressure ulcer on his sacro-coccyx area which measured 5 centimeters (cm) by 5 cm by 3 cm. The physician's order indicated to cleanse the pressure ulcer with normal saline, pat dry, apply santyl ointment, pack wound lightly with gauze, and cover with dry dressing daily, and low air loss mattress. On April 20, 2012, at 6 p.m., during the initial tour of the unit, Resident 1 was observed lying on a low air loss mattress and an indwelling catheter in place. On April 21, 2012, at 1:30 p.m., during the treatment observation, the resident was noted wearing a diaper and a bed sheet over the low air loss mattress. The resident's Stage IV pressure ulcer had healed but had redness of the skin on the coccyx area that measured 7 cm by 7 cm. During a concurrent interview with the treatment nurse, she stated that the resident should not be wearing diaper while lying in a low air loss mattress. On April 23, 2012, at 10 a.m., during an interview with the DON, he stated that for the low air loss mattress to achieve maximum effectiveness, a single linen/sheet should be use to promote	F 314	F314 Resident 1 diaper was removed immediately D.O.N. and DSD inserviced all Licensed nurses and C.N.A's regarding single barrier on bed for residents on low air mattress on 4/21/12 DSD on her daily rounds will monitor for compliance Treatment nurse will also monitor for compliance when providing treatments Overall compliance will be monitored quarterly by QA Committee	5/21/12

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F 314	Continued From page 12 wound healing.	F 314		
F 315 SS=E	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 review, the facility staff failed to ensure that a resident with an indwelling catheter was being monitored for signs and symptoms of urinary tract infection such as cloudiness and sediments in the urine and to assess the adequacy of the resident's fluid intake (1), ensure that the urine drainage tube connected to an indwelling catheter would not touch the floor to prevent the potential for urinary tract infection, and to provide the care and services to restore as much normal bladder function as possible (6) for two of 13 sampled residents (1,6). Findings: a. On April 20, 2012, at 6 p.m., during the initial tour of the unit, Resident 1 was observed in bed with an indwelling catheter in place. The indwelling catheter bag contained 400 cubic	F 315		

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F 315	Continued From page 13 centimeters (cc) of cloudy, yellow colored urine. On April 21, 2012, at 1:30 p.m., during the treatment observation with Licensed Vocational Nurse (LVN) 2, the indwelling catheter bag was noted to have 600 cc of cloudy, yellow colored urine. On April 22, 2012, at 4:20 p.m., together with the director of nursing (DON), the indwelling catheter bag was observed draining 150 cc of cloudy, yellow colored urine. A review of the medical record indicated Resident 1 was admitted to the facility on December 6, 2011, with diagnoses that [redacted] Stage IV pressure ulcer on the sacro-coccyx area, and hypertension. A care plan developed on admission addressed the resident's indwelling catheter for the purpose of wound care management. One of the approaches was to monitor urine for signs and symptoms of urinary tract infection such as increased sediments, change in color of urine (cloudiness). There was no documented evidence that indicated the resident's fluid intake was assessed to evaluate the need to increase fluid consumption in order to prevent sedimentation and cloudiness of the urine. On April 22, 2012, at 4:30 p.m., in an interview with the DON while reviewing Resident 1's medical record revealed there was no documentation in the licensed nurses notes that indicated the cloudiness and yellow-colored urine	F 315	F315 Catheter bag of resident 1 and 6 was changed and tubing properly placed off the floor immediately 4/22/12 All licensed nurses were inserviced by nurse consultant regarding catheter assessment and monitoring on 04/21/12 All licensed nurses were inserviced by D.O.N. on infection control on 4/21/12 All licensed nurses were inserviced by D.O.N. on proper documentation of intake and output on 4/21/12 All licensed nurses were inserviced by D.O.N. on 4/21/12 regarding documentation of monitoring residents on Coumadin therapy for signs and symptoms of bleeding. D.O.N. will randomly check catheter care and monitoring on daily rounds A plan of care was immediately developed for Resident 6 by D.O.N. on 4/22/12	

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F 315	Continued From page 14 was identified from April 20 through 22, 2012. b1. On April 20, 2012 at 7:00 p.m., during the tour of the facility, Resident 6 was observed lying in bed with a GT feeding and an indwelling catheter in place. The resident's bed was in a low position with the catheter tubing touching the floor and the urine was dark amber in color. The licensed staff stated that the tubing should not touch the floor. A review of the medical record indicated Resident 6 was initially admitted to the facility on March 19, 2012, and re-admitted on April 12, 2012, with diagnoses that included pneumonia, dysphagia, muscle weakness, gastrostomy tube, and status post pacemaker placement. The Minimum Data Set (MDS) assessment dated March 31, 2012, indicated the resident had no memory problem, independent in cognitive skills for decision making, and needed limited to extensive assistance in activities of daily living. On April 22, 2012 at 10 a.m., the resident was observed with Licensed Vocational Nurse (LVN) 2 and the urine was noted to be reddish in color. At 2:00 p.m., Registered Nurse (RN) 1 was asked to check the resident's urine and after checking the urine, she stated that the urine was bloody and the staff should be monitoring the urine for hematuria as the resident was on Coumadin therapy (blood thinner that reduces the formation of blood clots). A review of the medical record with RN 1 revealed no documentation that the staff was continuously monitoring the resident for signs of bleeding.	F 315	F315 All licensed nurses were inserviced by D.O.N. in appropriately care planning residents B&B retraining program on 4/22/12 4/22/12 Medical Records will audit monthly for compliance Overall compliance will be monitored quarterly by QA Committee	

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F 315	Continued From page 15 b2. The physician's order dated March 21, 2012, indicated order to remove Foley catheter and to start Bowel and Bladder (B/B) retraining program times 14 days. The care plan for bowel and bladder retraining was developed and the approaches included to toilet resident at specified times (did not indicate the times) and encourage adequate fluids. A review of the B/B Retraining Program did not indicate a plan of care with specified time and/or scheduled toileting program in order to achieve the goal to restore as normal bladder function as possible. There was no documentation that the resident was assessed on the progress of the program nor was the resident encouraged for fluid intake. A review of the policy on Bowel & Bladder Retraining Program indicated that appropriate fluid intake shall be encouraged throughout the study and that weekly progress notes will be performed by a licensed nurse.	F 315		
F 322 SS=E	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:	F 322		

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F 322	Continued From page 16 Based on observation, interview and record review, the facility failed to ensure a resident who was fed by a gastrostomy tube (GT-tube surgically placed into the stomach through the abdominal wall into the stomach and is used for long-term enteral nutrition and medication administration) received the volume of feeding formula as ordered by the physician for two of 13 sampled residents (2, 3, 4, 7). Findings: a. On April 20, 2011, at 7 p.m., during the initial, Resident 4 was observed lying in bed with GT feeding of Glucerna 1.2 Cal infusing at 50 cc. The label on the bottle indicated it was hung on April 20, 2012 at 8 a.m. There was 1400 cc left in 1500 cc bottle. On April 21, 2012, at 4:30 p.m., together with Licensed Vocational Nurse (LVN) 4, the resident's feeding was observed running at 50 cc. The label on the bottle indicated Glucerna 1.2 Cal, hang on April 20, 2012, at 8 a.m. (same bottle observed a day earlier) with 300 cc left in a 1500 cc bottle. During a concurrent interview with the staff was unable to give an explanation for the occurrence. She further stated it should have been finished by now. On April 22, 2012, at 8:25 a.m., the resident was observed in bed with his feeding running at 50 cc. The label on the bottle indicated Glucerna 1.2 Cal hang on April 21, 2012, at 8:45 p.m., with 1100 cc left in a 1500 cc bottle.	F 322	F322 Resident 4 and 3 were both immediately weighed to monitor for weight loss 4/21/12 Orders were obtained from MD for labs to monitor if within normal limits on 5/08/12 Schedule was instituted to start all GTF at the same time for monitoring of infusion. All licensed nurses were inserviced by nurse consultant regarding GTF infusion as per physician order on 4/23/12 D.O.N. and DSD will monitor for compliance on daily rounds. Overall compliance will be monitored quarterly by QA Committee.	5/8/12

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F 322	Continued From page 17 A review of the medical record revealed a physician order dated December 30, 2011 , tube feeding order every shift Glucerna 1.2 at 50 ml/hr to provide 1000 ml/1200 cal via GT ever 20 hours via pump, start infusion at 12-1 p.m. and continue until total volume is infused. Set pump at 50 cc/hr. b. On April 20, 2012, at 6 p.m., during the initial tour , Resident 3 was observed lying in bed with GT feeding of Jevity 1 Cal infusing at 60 cubic centimeters (cc) . The label on the bottle indicated the feeding bottle was hang on April 19, 2012, at 1:30 p.m. There was 250 cc left of the feeding in a 1500 cc bottle. On April 21, 2012, at 4:30 p.m., together with LVN 4 the resident was observed in bed with the feeding off. The label indicated Jevity 1 Cal was hang on April 20, 2012, at 9 p.m. There was 60 cc left in a 1500 cc bottle. On April 22, 2012, at 8:35 a.m., the resident was observed in bed with his feeding running at 60 cc . The label indicated Jevity 1 Cal was hung on April 22, 2012, at 2 a.m., with 1200 cc left of a 1500 cc. At 3 p.m. an observation with the DON, the feeding and the pump was recheck which indicated that 1100 cc was infused. A review of the medical record revealed a physician order dated December 13, 2011, tube feeding order Jevity 1.0 at 60 cc /hr x 20 hours to provide 1200 ml /1200 Kcal start infusion between 12 - 1 p.m. and continue until total volume infused. c. On April 20, 2012, at 7:30 p.m., during the	F 322		

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F 322	Continued From page 18 initial tour, Resident 2 lying in bed with GT feeding of Glucerna 1.0 Cal infusing at 50 cc. The label on the bottle indicated the feeding was hang on April 20, 2012, at 6:30 p.m. On April 21, 2012, at 4:30 p.m., together with the LVN 4, the resident's feeding was infusing at the rate of 50 cc. The label on the bottle indicated the feeding was hang on April 20, 2012, at 6:30 p.m. There was 700 cc left in a 1500 cc bottle. A review of the medical record revealed a physician order dated November 11, 2011, Glucerna 1.0 TID (three times a day) at 50 cc/hr to provide 1000 ml/1000 cal/day, per GT every 20 hours via pump, start infusion at 12-1 p.m. and continue until total volume is infused. d. A review of the medical record revealed Resident 7 was readmitted to the facility on March 30, 2012, with the diagnoses that included diabetes mellitus, hypertension, seizure disorder and gastrostomy tube feeding. The resident was readmitted to the facility under hospice care. A review of the Minimum Data Set (MDS) assessment dated April 11, 2012, indicated the resident was [redacted], was totally dependent on staff for activities of daily living, and was on feeding tube. The resident has a physician's order for GT feeding of Glucerna 1.0 at 55 cc per hour for 20 hours, to start infusion at 12 - 1 p.m. and continue until total volume is infused. On April 22, 2012 at 9:55 a.m., the resident was observed sitting up in a wheelchair with GT	F 322		

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F 322	Continued From page 19 feeding at 55 cc/hour. The label on the bottle indicated that it was hung on April 22, 2012 at 4:10 a.m. The bottle contained 1500 cc's and was still almost full. The pump indicated that 1033 cc of the feeding had been infused. At 1:30 p.m., together with Registered Nurse (RN) 1, there was about 1400 cc's left of the feeding. RN 1 asked LVN 2 what time she turned on the feeding tube. LVN 2 stated that she turned the feeding tube on or at about 1:00 p.m. RN 1 stated that 275 cc's of the feeding should have been infused. Based on the physician's order to start the infusion at 1:00 p.m. and continue until the total volume is infused, the total volume should have been finished by 9:00 a.m. to run for 20 hours. However at 9:55 a.m., there was still 67 cc left of the feeding to be infused.	F 322		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the resident was provided sufficient fluid by monitoring the intake and output (I&O) accurately as ordered by the physician for two of 13 sampled residents (6, 7) Findings:	F 327		

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F 327	Continued From page 20 a. During the tour of the facility on April 20, 2012 at 7:00 p.m., Resident 6 was observed lying in bed with a GT feeding at 60 cubic centimeters (cc) per hour and an indwelling catheter in place. A review of the medical record revealed Resident 6 was initially admitted to the facility on March 19, 2012, and re-admitted on April 12, 2012, with diagnoses that included pneumonia, dysphagia, muscle weakness, gastrostomy tube (GT), and status post pacemaker placement. The Minimum Data Set (MDS) assessment dated March 31, 2012, indicated the resident had no memory problem, independent in cognitive skills for decision making, and needed limited to extensive assistance in activities of daily living. The resident had the following physician's order on admission: 1. Jevity 1.2 at 60 cc per hour 2. Flush GT with 250 cc every six hours and 30 cc's post and pre medication administration 3. Monitor intake and output times 4 weeks 4. The flushing of GT with 250 cc of water was held on April 14 and 15, 2012, and a physician order to flush 250 cc of water every four hours times two days was received. There was also an order for water bolus of 500 cc times one. A review of the Intake/Output Flow Sheet indicated that on April 14, 2012, the resident received 2200 cc of fluid. However, the resident	F 327	F 327 Orders obtained from MD to monitor if labs within normal limits for residents 6 and 7 on 5/08/12 Licensed nurses were inserviced by D.O.N. on proper documentation of intake and output on 4/21/12 Medical Records will audit monthly for compliance. Overall compliance will be monitored quarterly by QA Committee	5/8/12

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F 327	Continued From page 21 should have received 3130 cc of fluid. On April 15, 2012, it was documented that the resident received 2280 cc of fluid. However, the resident should have received 2880 cc of fluid. On April 23, 2012 at 11:00 a.m., in an interview and record review with the director of nurses, he stated that the intake information probably did not include the flushing and he will inservice the staff to document accurately. b. During the tour of the facility on April 20, 2012 at 7:30 p.m., Resident 7 was observed in bed with gastrostomy tube feeding. A review of the medical record revealed Resident 7 was readmitted to the facility on March 30, 2012, with the diagnoses that included diabetes mellitus, hypertension, seizure disorder, and gastrostomy tube feeding. A review of the Minimum Data Set (MDS) assessment dated April 11, 2012, indicated the resident was [redacted], was totally dependent on staff for activities of daily living, and was on feeding tube. The resident had the physician's order on admission as follows: 1. GT feeding of Glucerna 1.0 at 55 cc per hour for 20 hours 2. Flush feeding tube with 200 ml of water every shift 3. Flush feeding tube with 30 cc of water pre and post medication administration 4. Monitor intake and output A care plan dated April 11, 2012, identified the	F 327		

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F 327	Continued From page 22 problem of at risk for dehydration related to tube feeding. One of the approaches was to monitor intake and output daily. A review of the medical record revealed there was no documentation that intake and output was monitored. On April 22, 2012 at 6:20 p.m., in an interview with Licensed Vocational Nurse 3, he stated that I & O should be done within 30 days of admission and that the monitoring was not done.	F 327		
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 nursing staff failed to ensure the resident received the voulme of oxygen as ordered by the physician for one of 13 sampled residents (11). Findings:	F 328		

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F 328	Continued From page 23 On April 20, 2012 at 6:45 p.m., Resident 11 was observed with oxygen via nasal cannula at 3.5 liters. A review of the medical record with Licensed Vocational Nurse (LVN) 1 after the observation, revealed Resident 11 had a physician's order for oxygen at 2 liters per nasal cannula. LVN 1 stated she will adjust the oxygen as per physician's order.	F 328	F328 Residents 11 Oxygen was adjusted immediately per physicians order All charge nurses were inservice by D.O.N. on 4/21/12 re: residents to received volume of oxygen as ordered by physician D.O.N. and DSD will monitor for compliance on daily rounds Overall compliance will be monitored quarterly by QA Committee	4/21/12
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. 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 on 1800 calories diet was was provided the therapeutic diet as ordered by he physician for one of 13 sampled residents (11). Findings: A review of the medical record revealed Resident 11 was re-admitted to the facility on April 12, 2012, with diagnoses that included coronary heart failure, anemia, hypertension and seizure disorder. The Minimum Data Set (MDS) assessment dated February 21, 2012, indicated the resident usually made self understood and could understand others, totally dependent on staff for dressing and needed extensive assistance with the rest of her	F 367		

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F 367	Continued From page 24 activities of daily living, had limitation on one side of the upper extremity, and on therapeutic diet. A review of the physician's order on admission indicated the resident was to receive 1800 calories diet. On April 23, 2012 at 7:15 a.m., an observation of the tray line revealed there was only one resident on 1800 diet. The dietary staff gave the same amount of food as the regular diet. A review of the menu spread sheet indicated that residents on 1800 calories was to receive 1/2 cup of the oatmeal while the regular diet gets 3/4 cup. On the same date at 7:30 a.m., the dietary supervisor stated in an interview that their policy calls for the same portion for breakfast. However, when she was shown the spread sheet, she stated that she will in-service the staff to follow the menu spread sheet.	F 367	F367 Resident 11 portion was corrected and was give ½ cup of oatmeal immediately Dietary Staff was inserviced by DSS on 4/23/12 on correct portion for therapeutic diet Inservice on proper portion control for therapeutic diet was given to all dietary staff by RD on 5/1/12 Daily compliance will be monitored by DSS Overall compliance will be monitored quarterly by QA Committee	5/1/12
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		

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F 425	Continued From page 25 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent omission of medication ordered by the physician, ensure liquid medication poured in excess would not be returned to the bottle to prevent the potential for contamination. Findings: a. On April 21, 2012, at 8 a.m., during the medication pass observation, the following was noted: 1. Licensed Vocational Nurse (LVN) 1 was observed preparing medications for Resident 2. The medications were Metronidazole 500 mg, Aspirin 81 mg, Aminophyline 200 mg, Metropolol 25 mg, Cranberry pill 405 mg, Tylenol 325 mg, Vitamin D 1000 IU and MVI 5 cc. The above medications were administered via gastrostomy tube. A review of the resident's medical record revealed a physician's order dated February 11, 2012, for a ProMod 30 ml daily for low albumin. This was not observed administered during the	F 425	F 425 LVN was inserviced immediately by D.O.N. on administration of medication and disposable of unused medication All charge nurses were inserviced by D.O.N. on administration and disposable of unused medication on 4/22/12 Consultant Pharmacist will follow medication pass and observe for compliance monthly Overall compliance will be monitored quarterly by QA Committee	5/22/12

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F 425	Continued From page 26 medication pass observation. 2. LVN 1 was observed poured the MVI to a plastic medication cup which was more than the ordered dose for Resident 2. The licensed nurse poured back to the bottle the excess medication. A review of the facility's policy on Procedures for All Medications stipulated once removed from the container or package, unused doses should be disposed of in accordance with the medication destruction policy. During a concurrent interview with the DON, he stated unused doses of medication should be disposed of in the medication waste container.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. BUILDING _____ B. WING _____	04/23/2012

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F 431	Continued From page 27 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: based on observation interview and record review, the facility failed to ensure the proper storage of medication in the right temperature, ensure multidose medication was labeled with date opened, and ensure expired medications were removed from storage to prevent the administration of expired medication. Findings; a. On Apri 21, 2012, at 11 a.m., during the medication storage inspection the following was observed. 1. The medication storage refrigerator in the medication room had heavy accumulation of ice in the freezer. 2. The medication storage refrigerator had a temperature of 32 degrees Fahrenheit.	F 431	F431 Medication refrigerator was defrosted and cleaned immediately 4/21/12 All medications were ordered and replaced on 4/21/12 Inservice was given to all licensed nurses to keep refrigerator clean, defrosted and maintain acceptable temperature for medication on 4/21/12 Temperature of medication refrigerator was adjusted to be in compliance	4/21/12

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F 431	Continued From page 28 3. There was a bottle of [redacted] 2 mg/ml which was open and undated. 4: There were two bottles of sterile saline solution which had an expiration date of August 2010. Review of the daily log check revealed it was checked on April 21, 201. b. The First Aid Kit in the Disaster Kit was found to contain the following medications: 1. A vial of Ocu Fresh Eye Wash with expiration date of 2/28/11 2. Individuals packets of Povidone Iodine Prep Pad with expiration date of May 2011. 3. Individual packets of Insect Sting Relief with expiration date of July 2011. 4. Individual packets of Quick and Clean with expiration date of October 2011. 5. Individual packets of antibiotic ointment (Bacitracin Zinc Ointment) with expiration date of May 2011. 6. Individual packets of burn Cream, with Aloe Vera with expiration date of February 2011.	F 431	F 431 All expired medication were disposed and replaced immediately 4/21/12 Central Supply and licensed nurses were inserviced by D.O.N. regarding replacement of expired medication on 4/23/12 D.O.N. and DSD will monitor for compliance monthly Overall compliance will be monitored quarterly by QA Committee	4/23/12
F 465 SS=B	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.	F 465		

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F 465	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the environment in good working condition. Findings: On April 2, 2012 at 5:00 p.m., during the tour of the environment the following was observed: a. The door leading outside from the laundry room had about a 1/2 inch gap from the floor that could be a potential for vermin entry. b. The wall by the dryer was buckled. c. The screen door in Room 11 was warped. d. The refrigerator in the employees lounge was dirty and the shelf was broken. The maintenance supervisor stated at the time of the observation that he will have the above items fixed.	F 465	F 465 The gap in the door was installed with a barrier on 4/23/12 The wall was patched and fixed on 4/23/12 The screen door was straightened and installed on 4/23/12 Shelf was removed and refrigerator cleaned immediately on 4/22/12 Maintenance Supervisor will monitor for compliance on daily rounds	4/23/12
F 514 SS=F	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.	F 514	Overall compliance will be monitored quarterly by QA Committee	

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F 514	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the medical records were accurately documented for 13 of 13 sample residents. Findings: On April 22 and 23, 2012, a review of the Certified Nursing Assistant (CNA) ADL Sheet indicated the CNA were documenting under personal hygiene that the residents were provided bed bath every shift. On April 23, 2012 at 10:30 a.m., the director of nurses was shown the documentation that the residents were given a bath every shift on a daily basis. He stated that it was inaccurate and that all the CNAs will be in-serviced to document accurately.	F 514	F 514 ADL sheets were modified to minimize inaccuracies in documentation Licensed nurses were inserviced by D.O.N. on proper documentation on C.N.A. ADL sheet on 4/24/12 All C.N.A's were inserviced by DSD on proper documentation on ADL sheets on 4/24/12 Medical Records will audit monthly for compliance Overall compliance will be monitored quarterly by QA Committee.	4/24/12