POC REVIEWED AND ACCEPTED [illegible]

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

PRINTED: 11/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055344	A. BUILDING _____ B. WING _____	10/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA CLAREMONT HEALTH	590 S. INDIAN HILL BLVD. CLAREMONT, CA 91711

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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: Surveyor ID #27785 Surveyor ID #17019 Surveyor ID #05379 Surveyor ID #07598 Total Resident Population: 85 Total Resident Sample Size: 17 Highest Severity and Scope: E	F 000	This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted. Country Villa Claremont Healthcare Center submits this response and plan of correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the provider or its employees, agents, officers, directors or shareholders.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to post the results of the most recent survey in a place readily accessible to residents and post a notice of their availability.	F 167	**F167**: Facility survey results have been posted at locations which are readily accessible to residents and a notice of their availability has been posted in the Consumer Information Board. All Residents have the potential to be affected by the deficient practice and they will continue to be reminded of the location of survey results during monthly Resident Council meetings. Survey results will be inspected monthly to ensure they are intact and posted as required to ensure the deficient practice does not recur. CQI Committee shall review the Resident Council meeting minutes to evaluate the effectiveness of the corrective actions.	11-16-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	11-17-12

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 167	Continued From page 1 Findings: During the initial tour of the facility on October 10, 2012, at 9:15 a.m., the evaluator could not find the survey results posted anywhere near the rooms or hallways where the residents congregate or walk by. During an interview with a facility staff member, she stated the survey results were available for review in the front lobby. The evaluator observed the survey results were placed in a notebook that was inside a desk drawer near the front entrance of the facility in the lobby area. There was no notice posted that the survey results were located in the desk drawer. Upon closer inspection, there was a small label on the outside of the desk drawer, measuring 3 inches by one-half inch that read "survey book". The desk in the front lobby where the survey report was located was at least 60 feet away from the nearest nurses' station where some of the residents pass by. During the course of the survey on October 10, 11, 12, 15, 16, and 17, 2012, no residents were seen socializing near the front lobby.	F 167		
F 241 SS=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	F 241	F241: Facility conducted staff in-service on 10-19-12 to ensure the predominant language of the residents is spoken in the facility by all staff at all times to promote an environment in which all residents' dignity is respected in full recognition of his or her individuality. The facility considers all residents to have the potential to be affected by the same deficient practice. The facility will carry out	

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F 241	Continued From page 2 by: Based on interview and record review of the minutes of the resident council meeting, the facility failed to ensure that the staff communicated in the predominant language of the residents in the facility. Seven of nine alert and oriented residents who attended the group meeting stated that staff members spoke in their native (foreign) language in their presence and while providing care, which made them feel disrespected and the residents did not like it. The deficient practice had the potential to result in a decline in the psychosocial well being of the residents. Findings: During the group meeting conducted on October 12, 2012 at 10 a.m. nine alert and oriented residents stated that the staff, mostly the Certified Nurse Assistants (CNA), would constantly speak their native language in their presence and while in the room providing care to their roommates. The residents further stated that at any given time of the day the staff would speak their native language to each other while walking down the hallway within their hearing distance. The residents stated they did not like staff speaking their native language to each other within their hearing distance, because it made them feel disrespected. The residents added, all staff must speak English which is the major and or predominant language of communication in the facility. The residents further stated this issue had been addressed in one of the resident council meetings.	F 241	progressive counseling for any staff who fails to follow the guidelines and expectations regarding the use of the predominant language of the residents. The facility will ensure the deficient practice does not recur by continually reminding staff of the proper language to be spoken during daily shift huddles, quarterly staff in-services and during orientation of all new employees. The facility will utilize feedback from the Resident Council meetings, the Administrator's Resident Advisory meetings and the facility grievance process to monitor performance and ensure that solutions are sustained. The CQI Committee shall review the Resident Council meeting minutes, notes from the Administrator's Resident Advisory meetings and grievance logs on a monthly basis to evaluate the effectiveness of the corrective actions.	11-16-12

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F 241	Continued From page 3 On 10/10/12, at 2 p.m., and 10/12/12, at 3:30 p.m. and 4:40 p.m., staff were communicating with each other in their native language while walking down the hallways with in hearing distance of residents who were sitting in their wheelchair and family members visiting the residents at the time of these observations. On 10/12/12, at 5 p.m., the charge was made aware and stated staff members are required to speak English in the presence of residents and visitors. During an interview conducted on 10/16/12 at 1:10 p.m., an alert and oriented sample resident stated the CNAs would communicate among themselves in Spanish while in her room. The resident stated the CNAs were rude and she did not like it. A review of the facility's policy and procedure titled "Residents Rights and Responsibilities" dated April 01, 2001, indicated "This facility will provide an environment that contributes to the resident's positive self image and preserve dignity and autonomy. The facility shall treat each resident with consideration, respect and full recognition of his/her dignity and individuality."	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	**F246**: Residents' call lights are expected to be answered within the time frame as indicated in the facility's policy and procedure. The facility's monthly Resident Council meeting minutes dated January 2012 – October 2012 indicate residents were satisfied with the call light response time (please see attached documents).. To help ensure residents' needs are met within a timely manner, Licensed Nurses were in-serviced on 10-24-12 to monitor and	

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F 246	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to answer the residents' call lights in a prompt manner for five of nine alert and oriented residents who attended the group meeting and for one randomly selected resident (RSR 19). This deficient practice resulted in a delay of services. Additionally, the facility failed to accommodate for one sample resident's preference to watch TV in a total of 17 sample residents (Resident 13). Resident 13's foot cradle hindered his view to such an extent that he was unable to watch television shows. This deficient practice resulted in an environment that hindered Resident 13's preference to watch television. Findings: a. During the group meeting conducted on 10/12/12, at 10 a.m., five of nine alert and oriented residents stated that it took approximately over 30 minutes for all shifts to answer their call lights most especially when they needed assistance to use the bathroom and or change their diapers. During an interview with Charge Nurse 1 on 10/15/12, at 10 a.m., he stated that all staff had been instructed to answer call lights within a reasonable time, within five to ten minutes to attend to residents' needs. b. A review of the "Admission Record" for Randomly Selected Resident 19 (RSR 19), indicated she was admitted to the facility on	F 246	personally respond to all call lights when assigned C.N.A.'s are unavailable. In addition, all facility staff including Department Heads are expected to promptly respond to all call lights while on the floor. The facility considers all residents as having the potential to be affected by the same deficient practice. Residents have been and will continue to be reminded during Resident Council and the Administrator's Advisory meetings to immediately report concerns they may have, including staff's response to their call light, so that corrective action can be initiated to avoid reoccurrence. To ensure the deficient practice does not recur, staff was in-serviced on 10-24-12 regarding the necessity and importance of timely call light response. The facility will utilize feedback from the Resident Council meetings, the Administrator's Resident Advisory group meetings and all related resident grievances to monitor performance and ensure solutions are sustained. The CQI Committee shall review the Resident Council meeting minutes, notes from the Administrator's Resident Advisory meetings and grievance logs on a monthly basis to evaluate for the effectiveness of the corrective actions. The facility will monitor its performance to make sure solutions are sustained by conducting resident satisfaction questionnaires to obtain their feedback on call light response. The facility will also continue to utilize the Residents' feedback obtained from the monthly Resident Council meetings as well as the Administrator's	

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F 246	Continued From page 5 10/19/09, with diagnosis that included diabetes mellitus type II, chronic pain, and anxiety state. A review of the minimum data set (MDS, a standardized assessment and care planning tool), dated 10/12/12, indicated RSR 19 had the ability to make self understood and understand others. The MDS indicated resident required extensive assistance from staff for bed mobility and personal hygiene, and was totally dependent on staff for transfer, dressing, toilet use, and bathing. MDS also indicated that the resident was always incontinent of bowel and bladder. During an interview with RSR 19 on 10/10/12 at 1:30 PM, she stated that it takes a long time before nurses could answer her call light especially during the 3 PM to 11 PM shift. The resident said that the week before, she waited for a half an hour before her nurse could bring her to the toilet. The resident said her stomach was hurting and could not wait for the nurse to bring her to the toilet. During an interview with the administrator on 10/16/12 at 11 AM, he stated that the reason RSR 19 has to wait for assistance to go to the toilet, was because resident wants only her permanently assigned nurse to assist and attend to her needs. The administrator further stated that sometimes when the resident calls for assistance, her nurse is busy and another nurse would offer to assist the resident. However, the resident would refuse and insisted on having her permanently assigned nurse. c. A review of the "Admission Record" for	F 246	Resident Advisory meetings to ensure correction is achieved and sustained. Resident 13 actually attends activities on a regular basis as is evidenced on the attached Activity attendance logs. He is also up for meals on most days. The TV in Resident 13's room was mounted on the wall on 10-17-12 to allow for unobstructed viewing. The Maintenance Supervisor conducted room rounds on 10-17-12 to ensure no other residents were affected by the same deficient practice. To ensure the deficient practice does not recur, Supervisors and Charge Nurses will inspect rooms on a daily basis and immediately document any deficient findings in the Maintenance log books for prompt remedies. Facility Department Heads will conduct weekly room checks to monitor performance to make sure solutions are sustained. The CQI Committee shall review Maintenance logs and room rounds checklists on a monthly basis to ensure all findings are corrected in a timely manner and to evaluate the effectiveness of the corrective actions.	11-16-12

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F 246	Continued From page 6 Resident 13, indicated he was originally admitted to the facility on 7/31/09, and was readmitted on 1/19/12, with diagnosis that included diabetes mellitus type II, hypertension, cirrhosis of the liver, neuralgia/neuritis, and bipolar disorder. A review of the minimum data set (MDS, a standardized assessment and care planning tool), dated 9/30/12, indicated Resident 13 had the ability to make self understood and understand others. The MDS indicated that it was very important for the resident, as part of his activity preference, to keep up with the news and do his favorite activities. The resident required extensive assistance from staff for bed mobility, transfer, and personal hygiene, and was totally dependent on staff for dressing, toilet use, and bathing. During an observation with the assistant care coordinator for nurse station 2 on 10/10/12 at 8 AM, Resident 13 was awake lying in bed. A foot cradle (a frame placed over the feet to prevent sheets or blankets from touching the resident) was in place and was covered with a blanket. A television (TV) set was observed in front of the resident's bed, placed on top of a waist high, built in table by the closet. The resident complained that the foot cradle prevented him from viewing and watching his TV. The assistant care coordinator stated that the foot cradle was used to prevent skin breakdown of the resident's feet, that can be caused by the pressure and friction of the blanket touching the feet. During an interview with Resident 13 on 10/15/12 at 2 PM, he again complained that the foot cradle prevented him from viewing and watching his TV.	F 246		

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F 246	Continued From page 7 The resident stated that he is in bed most of the time and watching TV would help him from "Getting crazy for doing nothing and staring at the ceiling." The resident said he told the nurses (on an unspecified date)that he does not need the foot cradle because his feet were fine and that the foot cradle is covering his view of the TV, however, the nurses did not do anything. During an interview with the charge nurse for Station 2 on 10/15/12 at 2:30 PM, she stated that the foot cradle was part of the resident's care plan to prevent skin breakdown. The charge nurse further said she would ask the maintenance staff to place the TV higher, (allowing for the resident to see the TV.)	F 246		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have the residents' responsible party or representative acknowledge the receipt or disposition of the residents' personal belongings upon discharge for two (Residents 16 and 17) of three closed records reviewed. The residents' responsible parties did not sign the inventory list forms upon discharge as required. This deficient practice had the potential to result in theft or loss of the residents' personal belongings.	F 250	F250: Responsible parties for discharged residents 16 and 17 were contacted by the facility's Social Services Designee to obtain the appropriate signatures to acknowledge the receipt and/or disposition of the respective resident's personal belongings. The facility has identified all discharged residents as having the potential of being affected by the same deficient practice. The Medical Records Designee will review discharged records on a weekly basis to ensure all discharged residents' inventory forms are properly completed and signed by the discharged resident or responsible party. Social Services Designee will continue to follow up with any deficient findings to obtain proper signatures acknowledging receipt and/or disposition of the respective resident's personal belongings. To ensure the deficient practice does not recur, Licensed Nurses were in-serviced	

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F 250	Continued From page 8 Findings: a. A review of the admission information record indicated Resident 16 was admitted to the facility on 6/29/12, with diagnoses that included chronic airway obstruction, renal (kidney) and urethral (is a tube that connects the urinary bladder to the genitals for the removal of fluids from the body) dysfunction, cachexia (wasting syndrome or loss of weight) and dementia. On 8/21/12, the resident expired. A review of the resident's inventory list on discharge indicated the resident's responsible party and or representative did not certify or acknowledge receipt of the resident's personal belongings. The section for the signature of the resident's responsible party was left blank including the signature of nurse releasing the belongings. In an interview with the social service designee (SSD) on 10/16/12 at 4:00 p.m., she stated that the family decided to donate the resident's belongings to the facility but she had failed to document the information. A review of the facility's policy titled "Clothing and Personal Items" taken from the social service manual dated 10/01/94, indicated "Upon discharge of a resident from the facility, the responsible party and a staff member will date and sign the "Certification of Receipt on Discharge" section of the inventory form to certify that the resident's personal effects were received.	F 250	on 10-25-12 regarding the requirement to follow the facility's "Clothing and Personal Items" policy for discharged residents' including the necessity to obtain signatures on the certification of receipt by staff and the responsible party of each discharged resident to certify that the resident's personal effects were received. Social Services Designee was in-serviced on 10-25-12 to document on the resident's inventory form for those who have donated any personal belongings to the facility. Medical Records Designee's audits of discharged records will be used to monitor the facility's performance to ensure solutions are sustained. The CQI Committee shall review the MRD audits on a monthly basis to evaluate the corrective action for its effectiveness.	11-15-12

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F 250	Continued From page 9 If belongings are donated to the facility, the SSD should make a note of that fact on the inventory form." b. Resident 17 was admitted to the facility on 9/16/12, with diagnoses that included hypertension, peripheral vascular disease, and history of myocardial infarction (heart attack). On 10/4/12, the resident was transferred to the acute hospital for a complaint of chest pain. A review of the resident's inventory list on discharge revealed that the upper portion of the form had not been signed by the resident or the family members. The signature signifies that the resident's belongings had been received either by the resident or the family members. During an interview with a social service staff on 10/17/12 at 5:08 p.m., she stated that she was not aware of where the resident's belongings were. The facility's job description of the social services director indicated, "Assures that residents' clothing and other specific needs are met, contacting family as needed, etc." The facility's policy and procedures, titled "Clothing and Personal Items," effective 10/1/94 indicated, "Upon discharge of a resident from the facility, the resident or responsible party and a staff member will date and sign the "Certification of Receipt on Discharge" section of the Inventory form to certify that the resident's personal effects were received."	F 250		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279	F279: Resident 9's clinical record indicates	

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F 279 SS=D	Continued From page 10 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 and implement a resident specific plan of care for one (Resident 9) out of 17 sampled residents. Resident 9 had a 10 pounds (lb) weight gain in one month, from 9/1/12 to 10/1/12, however, there was no plan of care developed to address the weight gain. This had the potential to result in further unplanned weight gain for the resident. Findings:	F 279	the Attending Physician was in fact notified on 10-05-12 at 2:00 PM of the Resident's 10lb weight gain during the month from September 01 – October 01, 2012. Additional notes dated 10-05-12 indicate there were no negative effects related to the 10lb weight gain (please see attached). However, the care plan that was initiated on 10-05-12 was only for seven days. Resident 9's care plan was revised on 10-17-12 to include other interventions as well as monitoring weight and/or any negative effects related to weight gain for 30 days. MRD conducted a change of condition audit on 10-18-12 to identify other residents having the potential to be affected by the same deficient practice. DNS and RCC will continue to follow up with any noted deficient findings to ensure solutions are sustained. To ensure the deficient practice does not recur: A one on one in-service regarding appropriate care plan procedures was provided to the responsible Licensed Nurse on 10-17-12; a mandatory Licensed Nurses in-service was held on 10/25/12 regarding appropriate care plan procedures upon any COC; the RCC will use the results of the assessments from any triggered problem or condition in order to develop, review and revise the residents' comprehensive plan of care. MRD will perform audits of care plans 5x/week with changes of condition/ revised care plans for appropriateness. MRD audits will be reviewed by the Administrator and DNS to ensure solutions are sustained. The	

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F 279	Continued From page 11 During an observation on 10/10/12 at 8:15 AM, Resident 9 was observed in bed and asleep. The resident's head was elevated 30 degrees and a feeding formula (Glytrol), connected to the gastric (stomach) tube (G-tube), was running at 87 milliliters (ml) per hour via a feeding pump with 1110 ml infused. The assistant care coordinator stated the resident also eats food for oral gratification. The clinical record for Resident 9 was reviewed on 10/11/12 and 10/15/12. The admission information sheet (face sheet), indicated resident was originally admitted to the facility on 2/7/08 and was readmitted on 5/6/12, with diagnoses that included dementia, diabetes mellitus, hypertension, late effect hemiplegia, and dysphagia. The latest comprehensive Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 8/11/12, indicated Resident 9 was able to make self understood and understand others and does not have any mood or behavior problems. The resident required extensive assistance from staff for eating, and was totally dependent on staff for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. The MDS also indicated that resident had a feeding tube, a mechanically altered, therapeutic diet while a resident of the facility. A review of the physicians order sheet indicated that on 8/25/12, Resident 9 had an order for Glytrol (a feeding formula) thru the G-tube to provide 1392 ml per 1392 calories at 87 ml per hour in 16 hours. On 8/27/12, the resident was	F 279	CQI Committee will evaluate the system on a monthly basis for its effectiveness.	11-16-12

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	055344	A. BUILDING _____ B. WING _____	10/17/2012

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F 279	Continued From page 12 also ordered to have mechanically soft diet with no added salt (NAS) by mouth and nectar thick liquids for lunch in small portions only. However, the September 2012 medication administration record (MAR) indicated Resident 9 was receiving the diet three times a day from September 1 to September 27, 2012. A review of the resident's weight report indicated Resident 9 had a weight gain of 10 lb in one month from 9/1/12 to 10/1/12. However, further review of the clinical record indicated that there was no plan of care developed to address the weight gain. A plan of care regarding alteration in nutrition for tube feeding due to dysphagia dated 5/6/12, indicated for the resident to maintain stable weight, and for staff to monitor weight and notify the physician for weight changes of five lb or more in a month. There was another plan of care dated 5/6/12, regarding potential for nutritional risks related to the enteral feeding with transition to oral feeding, that indicated to monitor weight routinely or as ordered and to notify physician for any significant changes. A review of the clinical notes revealed an entry from nursing, dated 10/6/12, regarding a 10 lb weight gain in one month, however there was no indication that the physician was notified and or that the weight gain was addressed. During an interview with the Director of Nursing (DON) on 10/17/12 at 2:30 PM, she stated that a short term care plan goal (7 days) for Resident	F 279		

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F 279	Continued From page 13 9's weight gain was developed. The DON said the care plan developed for weight gain was not in the active record because the concern was resolved already. There was no indication in the active record, however, that the weight gain was addressed and or that the resident's weight was checked before concluding the weight gain was resolved and the care plan goal was achieved.	F 279		
F 309 SS=E	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's staff failed to provide care and services that maintained the highest practicable well-being for two (Residents 2 and 3) of 17 sample residents and a randomly-selected resident (RSR 18). Laboratory tests were not done for Residents 2 and 3 as ordered by the physician, and RS 18's was administered the wrong form of vitamin B-12. Findings: a. Resident 3 was admitted to the facility on 4/29/12, with diagnoses that included chronic airway obstruction, peripheral vascular disease, hypertension and diabetes. The resident also	F 309	F309: (A) Resident 3's CMP and CBC were ordered on 10-16-12. (B) Resident 2's CMP, CBC and Pre-Albumin were ordered on 10-15-12. No new orders were given by either Resident 2 or 3's Attending Physicians. (C) The sublingual form of Vitamin B12 was available on 10-11-12 and has since been administered to Randomly Selected Resident 18. The Pharmacy Consultant will conduct monthly 3-way medication cart check and review and provide findings to DNS for follow-up. The Pharmacy Nurse Consultant and facility Nurse Resource Consultant will monitor the efficacy of 3-way medication cart check review system on their scheduled facility visits, discuss findings with Administrator and DNS and assist to develop specific action plans to enhance the system. MRD and facility's contracted laboratory designee conducted laboratory order audits on 10-15-12 to identify if other residents were affected by the same deficient practice with no further findings. To ensure the deficient practice does not recur, the Licensed Nurses were in-serviced on 10-25-12 regarding proper follow-up of routine lab orders; a one on one in-service was also provided to the responsible Licensed Nurse.	

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F 309	Continued From page 14 had a history of heart bypass surgery. The Minimum Data Set (a standardized assessment and care planning tool), dated 9/28/12, indicated the resident required assistance with daily activities such as transfers, bathing and personal hygiene. On 10/16/12, a review of the clinical records revealed a physician's order dated 4/29/12, to perform laboratory tests for CMP (comprehensive metabolic panel) and CBC (complete blood count) every first Tuesday of each month. However, there were no results of the laboratory tests ordered for May, June, July, August, September and October 2012. This was also confirmed during a record review and an interview with the RN Supervisor on 10/16/12 at 11:30 a.m. The RN Supervisor stated that the licensed nurse who obtained the physician's order failed to give her a copy of the order, which she would have used to coordinate with the laboratory company to perform the tests on a routine monthly basis, as the physician ordered. b. Resident 2 was admitted to the facility on 3/25/12, with diagnoses that included diabetes mellitus, chronic kidney disease, and peripheral vascular disease. The MDS assessment dated 7/8/12, indicated the resident required assistance with daily activities such as personal hygiene, dressing, and transfers. On 10/15/12 a review of the clinical records revealed a physician's order dated 8/14/12, to perform laboratory tests for CMP, CBC, and Pre-albumin (a test used to evaluate suspected poor nutritional status) every first Tuesday of	F 309	To monitor performance and make sure solutions are sustained, the RN Supervisor will review facility routine lab orders on the first and fifteenth of each month to determine if protocol is being followed and will report any discrepancies to the DNS for appropriate follow-up measures. The DNS will submit a summary trend analysis of the 3-way med cart check reviews and routine lab order findings to the CQI Steering Committee for further recommendations to ensure corrective actions are being evaluated for their effectiveness.	11-16-12

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F 309	Continued From page 15 each month. However, a record review and an interview with the RN Supervisor on 10/15/12 at 11:20 a.m., revealed the laboratory tests were not done for September and October 2012. The RN Supervisor stated that another licensed nurse who obtained the physician's orders failed to provide her a copy of the physician's order in order for her to coordinate with the laboratory company for the laboratory tests to be done monthly as the physician ordered. c. On 10/11/12 at 8 a.m., a licensed nurse was observed as he administered RS 18's morning medications. One of the medications was a tablet/pill of vitamin B-12 100 micrograms. During the observation, the resident stated that the vitamin B-12 pill that she received was of the wrong form. The resident stated that she usually receives vitamin B-12 in the form that has a thin film coating that she takes sublingually (under the tongue). The resident stated the taste of the vitamin B-12 that she was provided today was not pleasurable. At the same time, record review and inspection of the vitamin B-12 bottle label with the licensed nurse, revealed that the licensed nurse administered the wrong form of the medication. According to the physician's order dated 10/11/12, vitamin B-12 was to be administered sublingually, and therefore the resident should have received vitamin B-12 in a sublingual form. Instead, an oral form of vitamin B-12 was provided. The licensed nurse acknowledged that he administered the wrong form of vitamin B-12.	F 309		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318	F318: DNS made a late entry on 10-16-12	

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F 318	Continued From page 16 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide alternative services / measures to prevent further decline in range of motion for one of 12 sample residents with joint mobility limitations in a total of 17 sample residents (Resident 5). Resident 5 was assessed as having contractures to both upper and lower extremities, had refused to wear resting splints to the left hand, bilateral ankle splints and range of motion (ROM) exercises on multiple occasions. The resident was not provided other alternative measures to maintain or prevent further decline in ROM. The deficient practice had the potential to result in further decline in the resident's ROM capability. Findings: A review of Resident 5's admission information record on 10/ 10/12, indicated the resident was admitted to the facility on 1/25/08. Resident 5's diagnoses included: late effects of cerebro vascular accident (CVA- stroke) with left sided hemiplegia (paralysis), dislocated hip with prosthesis, (An artificial device used to replace a	F 318	regarding Resident #5's refusal of splints. Alternative measures include: Attempting to perform ROM exercises and applying splints when Resident's daughter is present. Resident and family education was done regarding the risks and benefits of use of splints and importance of ROM exercises on 10-16-12. Responsible party was informed that she will be notified if Resident refuses ROM exercises or use of splints so responsible party can assist in offering encouragement to Resident. Resident's care plan was updated and revised on 10-19-12 to administer pain medications prior to use of splints or range of motion exercises. Restorative nursing meetings will be held weekly to review Residents' status and identify other Residents having the potential to be affected by the same deficient practice. To ensure the deficient practice does not recur, facility staff were in-serviced on 10-19-12 and 10-25-12 regarding alternative measures to be followed if and when Residents refuse the treatment plan of ROM and splinting. DNS will review the weekly Restorative Nursing Program's notes to monitor facility's performance and to make sure solutions are sustained. The CQI Committee will review the summary of concerns and issues from the Restorative Nursing Program on a monthly basis to evaluate corrective actions for their effectiveness.	11-16-12

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F 318	Continued From page 17 missing body part, such as a limb), hypertension (high blood pressure), osteoporosis (brittle bones or lacking in bone mass), diabetes mellitus (high sugar in the blood) and dementia (loss of brain function). A review of the most recent Minimum Data Set (MDS- is a standardized assessment and care screening tool) dated 7/23/12, indicated that the resident was able to usually make self understood and understands others. However, the resident was unable to recall date, time and simple objects. Additionally, Resident 5 required extensive to total nursing assistance to perform activities of daily living including toilet use and personal hygiene and grooming and had impairments on one side of the upper extremity and both sides of the upper extremities. On 7-28-12, the physician had ordered the following: Restorative Nursing Assistant (RNA)-to do passive range of motion (PROM) exercises daily seven times a week, apply left resting hand splint (treats moderate flexion contractures [a tightening of muscles that prevents normal movement of the associated limb or other body part]) of the wrist, hand or thumb. On 9/01/12, a plan of care was developed that addressed the resident's potential for the development of contractures due to diagnoses of degenerative joint disease (DJD- also known as arthritis is caused by inflammation, breakdown and eventual loss of the cartilage of the joints) and rheumatoid arthritis (a long term disease that leads to inflammation of the joints). The care plan goal indicated complications related to arthritis will be prevented and detected promptly.	F 318		

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F 318	Continued From page 18 The care plan interventions included: Allow rest periods as needed, encourage daily exercise as tolerated and assist transfer and mobility. . However, the plan of care did not address the application of the splints to both upper and lower extremities and ROM exercises as additional interventions/measures and as ordered by the physician to maintain or prevent further decline in ROM. During multiple observations on 10/11/12 at 9 a.m., 11 a.m., 2 p.m. and 4 p.m., the resident was not wearing the resting hand splint and or the ankle splints while the resident was resting in bed. The resident's left hand as well as her feet were contracted. On 10/12/12, at 9 a.m., and 11:40 a.m., the resident was not wearing the bilateral ankle splints while she was in bed. On 10/16/12, at 9 a.m., 11:30 a.m., and 2:15 p.m., again, the resident was not wearing the resting hand splint and bilateral ankle splints while she was lying in bed. During an interview with the resident on 10/16/12 at 2:20 p.m., she stated "I don't want any splints because they hurt my hand and feet." In a separate interview with CNA 1 and RNA 1 on 10/16/12, at 3 p.m., and 10/17/12, at 4:05 p.m. respectively, they stated the resident many times had refused to wear the splints and ROM exercises and the charge nurse had been made aware each time. They further stated the resident would not give any reason as to why she would refused to wear the splints and to do ROM	F 318		

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F 318	Continued From page 19 exercises. On 10/16/12, at 3:20 p.m., Charge Nurse 1 stated during an interview that he was aware of the resident's refusal and had notified the physician. Charge Nurse 1 further stated resident had a pain medication ordered and was given to her as needed. Further review of the medical records indicated the plan of care was not revised to reflect the resident's multiple refusals to wear splints and to do ROM exercises and did not include alternative measures to prevent further decline in ROM, such as administration of pain medication prior to the use of the splint or providing ROM exercises to promote comfort during treatment necessary to prevent further contractures. Although the resident was identified by the nursing staff as refusing splinting and ROM exercises, the resident's therapy and joint assessments revealed no further assessment of the resident's refusal leading to alternate recommendations to prevent further contractures as follows: A review of the Occupational Therapy (OT) discharge recommendation dated 7/12/11, indicated to discharge the resident from skilled OT services as resident reached maximum benefit from skilled OT services. Resident will continue with RNA program for ROM/splinting.	F 318		

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F 318	Continued From page 20 A review of the Physical Therapy (PT) functional status record from 12/24/11 to 1/05/12, indicated "tendon pressure bilateral feet, ankle, care giver training, splinting. Contracted feet and ankles with risk for continued deformity. Short term goals; Increase ROM to bilateral ankles and feet. Tolerate splints three hours. On 1/06/12, the physical therapy notes indicated "Completed treatment recheck RNA stretching and application of splints, Discontinue skilled PT. A review of the "Annual Joint Mobility Screening" record dated 10/02/12, indicated the resident had maintained joint mobility and the therapist recommended to continue with RNA program. A review of the facility's policy and procedure titled "Splinting" dated 2/01/96, indicated: Prevent deformity caused by muscle tightness or joint contracture by placing the hand functional position. Prevent increased muscle imbalance by providing assistance to the weaker muscle group. For example a dynamic splint. This will enable weak muscles to work and allow active ROM.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323: Resident #8's wheelchair armrest was replaced with a new armrest on 10-17-12. Facility realizes all Residents have the potential to be affected by the same deficient practice. All wheelchairs were inspected by the Maintenance Supervisor on 10-17-12 to ensure all Residents' wheelchair armrests were in good repair and free of any worn areas that could be potential hazards to other residents.	

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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that a resident who was assessed as having multiple skin discolorations and skin tears was free from further injury for one of 17 total sample residents (Resident 8). The vinyl surface of Resident 8's right wheelchair armrest was rough and worn out exposing the sharp edges while the resident was sitting in the wheelchair and while resting her right arm on the armrest. This deficient practice had the potential to cause further skin discolorations and skin tears. Findings: During multiple observations on 10/10, and 10/11, 10/15, 10/16 and 10/17/12, between 9 a.m. and 3 p.m., Resident 8 was sitting in the wheelchair in her room or in the hallway across from Nursing Station 1. The resident's right arm had multiple scattered purplish discolorations. The vinyl surface of the right armrest of the wheelchair was rough, worn out and had multiple tears exposing some sharp edges. During the observations the resident would intermittently rest her right arm and or rub her arm against the surface of the armrest. During an interview with the director of staff development (DSD) on 10/10/12, at 9:30 a.m., she stated Resident 8 had very fragile skin and had history of bruises and skin tears. The DSD further stated the wheelchair was designated for the resident's own use.	F 323	Staff were in-serviced on 10-26-12 to inspect Resident wheelchairs prior to use and immediately report any concerns with equipment to ensure the deficient practice does not recur. Housekeeping staff will inspect wheelchairs during scheduled weekly wheelchair chair cleaning to ensure they are in good repair. All findings will be documented in the Maintenance Log books for proper servicing and repairs to ensure solutions are sustained. Maintenance Supervisor will conduct visual inspections of resident wheelchairs and report to CQI Committee on a monthly basis to that corrective actions can be evaluated for effectiveness.	11-16-12

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F 323	Continued From page 22 A review of Resident 8's admission information record on 10/12/12, indicated the resident was admitted on 3/12/07. Resident 8's diagnoses included: hypertension (high blood pressure), osteoporosis (brittle bones or lacking in bone mass), lack of coordination and dementia (loss of brain function). A review of the most recent Minimum Data Set (MDS- is a standardized assessment and care screening tool) dated 8/30/12, indicated Resident 8 was able to usually make self understood and understands others. Additionally, the resident required extensive to total nursing assistance to perform activities of daily living including toilet use and personal hygiene and grooming. On 5/21/10, the physician had ordered to administer Aspirin (a blood thinner) 81 milligrams (mg) enteric coated orally one tablet daily. (Aspirin is likely to cause easy bruising and or skin discoloration). On 3/12/07, a plan of care was developed which addressed multiple purplish discoloration to the right forearm. The care plan goal indicated the resident will have no signs and symptoms of complications with skin breakdown every shift. The care plan interventions included: Monitor for signs and symptoms for skin breakdown and complications, handle carefully and gently and assess and report to MD on skin status. However, the medical records did not contain documented evidence that the resident's skin condition was consistently monitored and reported to the physician.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	F371: The affected freezer's thermostat was	

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F 371	Continued From page 23 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the ice cream in the freezer was not stored under proper temperature conditions. Findings: During the initial kitchen tour on October 10, 2012 at 7:55 a.m., the thermometer in the floor freezer containing ice cream indicated a temperature of 10 degrees Fahrenheit. During an interview with the kitchen supervisor on October 11, 2012 at 11:45 a.m., she stated that the freezer needed to be adjusted. At this time the thermometer in the freezer read 0 degrees Fahrenheit. A review of the facility freezer temperature log sheet indicated that on October 10, 2012 at 5:00 a.m., the temperature of the freezer was 10 degrees Fahrenheit.	F 371	adjusted to bring the temperature down to zero degrees on 10-10-12. To identify other refrigerator/freezers having potential to be affected by the same deficient practice, the Dietary staff were in-serviced on 10-10-12 regarding proper freezer and refrigerator temperatures and to immediately report deficient findings to the Dietary Services Supervisor or the facility Supervisor in the absence of the DSS. To ensure the deficient practice does not recur Dietary staff were in-serviced on 10-10-12 to adjust thermostats accordingly to any affected refrigerator and/or freezer noted to be outside the required temperature and report immediately if the adjustment does not bring the affected unit to an acceptable temperature. Dietary Supervisor was in-serviced on 10-10-12 to monitor all temperature logs at beginning of shift to monitor performance to make sure solutions are sustained. The CQI Committee will review dietary temperature logs on a monthly basis to evaluate corrective actions for effectiveness.	11-16-12
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	F425: Resident #1"s dose of Xopenex was completed with no further episodes of	

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	055344	A. BUILDING _____ B. WING _____	10/17/2012

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F 425	Continued From page 24 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. 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's staff failed to ensure that one of 17 sample residents received the correct concentration of Xopenex (a medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing) as the physician ordered (Resident 1). Findings: According to the admission information, Resident 1 was admitted to the facility on 12/5/09, with diagnoses that included hypertension, dementia,	F 425	wheezing. The facility identified all residents with Xopenex orders to have the potential to be affected by the same deficient practice and all Xopenex orders were reviewed and confirmed to be accurate. A one on one in-service was done with the involved Licensed Nurse on 10-17-12 and all Licensed Nurses were in-serviced on 10-25-12 regarding the need to follow the concentration level of Xopenex orders to ensure the deficient practice does not recur. To monitor performance and make sure solutions are sustained, the Pharmacy Consultant will conduct monthly 3-way medication cart check and review and provide findings to DNS for follow-up. The Pharmacy Nurse Consultant and facility Nurse Resource Consultant will monitor the efficacy of 3-way medication cart check review system on their scheduled facility visits, discuss findings with Administrator and DNS and assist to develop specific action plans to enhance the system. The DNS will submit a summary trend analysis of the 3-way med cart check review findings to the CQI Steering Committee for further recommendations to ensure corrective actions are being evaluated for their effectiveness.	11-16-12

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F 425	Continued From page 25 and chronic rhinitis (irritation and inflammation of the mucous membrane inside the nose). The Minimum Data Set (MDS) a standardized assessment and care planning tool, dated 9/2/12, indicated the resident had short- and long-term memory problems and was dependent on staff to perform daily activities such as transfers, dressing and personal hygiene. A physician's order dated 9/20/12, indicated to administer Xopenex concentrate 30, 1.25 milligrams per 0.5 milliliter (1.25 mg/0.5 ml) via nebulizer machine as needed for wheezing. However, an inspection of the medication cart on 10/10/12, with a licensed nurse revealed that the pharmacy sent Xopenex 1.25 mg/3 ml, (a lower concentration of Xopenex than the physician ordered), instead of Xopenex 1.25 mg/0.5 ml. The licensed nurse acknowledged the facility's failure to ensure that the resident received the exact concentration of Xopenex that the physician ordered. The licensed nurse stated that it is each licensed nurse's responsibility to ensure that the resident received the correct concentration of medication as the physician ordered. The medication administration records revealed that the resident received Xopenex 1.25 mg/3 ml on 9/22/12, 9/23/12, 9/27/12 and 9/28/12 with results that it helped the resident with wheezing. The licensed nurse stated that the medication was effective and the resident did not exhibit any negative reaction.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F431: The expired medication was removed from the medication cart on 10-10-12. All medication carts were checked on 10-10-12	

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F 431	Continued From page 26 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: Based on observation, interview and record review, the facility's staff failed to ensure that residents were not administered expired medications. Resident 1's inhalation medication	F 431	to ensure there were no other expired medications. To ensure the deficient practice does not recur, a one on one in-service was done with the involved Licensed Nurse on 10-19-12 and all Licensed Nurses were in-serviced on 10-25-12 regarding the facility policy for discontinued and/or expired medications. To monitor performance and make sure solutions are sustained, the Pharmacy Consultant will conduct monthly 3-way medication cart check and review and provide findings to DNS for follow-up. The Pharmacy Nurse Consultant and facility Nurse Resource Consultant will monitor the efficacy of 3-way medication cart check review system on their scheduled facility visits, discuss findings with Administrator and DNS and assist to develop specific action plans to enhance the system. The DNS will submit a summary trend analysis of the 3-way med cart check review findings to the CQI Steering Committee for further recommendations to ensure corrective actions are being evaluated for their effectiveness.	11-16-12

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F 431	Continued From page 27 was still stored in the medication cart despite the manufacturer's instructions that it should have already been discarded. Findings: An inspection of Station 1's medication cart on 10/10/12, revealed a box of Xopenex inhalation medication with the foil package opened on 9/24/12 (16 days ago). According to the box label, "Once the foil pouch is opened, the vials should be used within two weeks. Once removed from the foil pouch, the individual vials should be used within one week..." There were 4 vials left in the foil package. The licensed nurse acknowledged that the vials should have already been discarded. The facility's policy and procedures, titled "Procedures for All Medications", dated April 2008, indicated for the licensed nurse to check the expiration date on the package. According to the clinical records, Resident 1 was admitted to the facility on 12/5/09, with diagnoses that included dementia, psychosis and chronic rhinitis (irritation and inflammation of the mucous membrane inside the nose).	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 463	F463: Maintenance Supervisor repaired the inoperable call-light in the shower room located near the ice machine on 10-16-12. Maintenance Supervisor made room rounds on 10-16-12 to ensure all call lights were working properly. Nursing staff will report any deficient findings with the call-light system in the maintenance log books and th Maintenance Assistant will conduct weekly call-light	

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F 463	Continued From page 28 Based on observation and interview, the facility maintenance staff failed to ensure that the call light in the shower room located near the ice machine was operable. Findings: On October 16, 2012 at 10:54 a.m., during an environmental inspection of the communication system between the nurses' stations and the bathing facilities, the call light in the shower room near the ice machine room was tested and the call cord did not initiate an audible sound or flashing light at the nurses station. At the same time, during an interview with the maintenance supervisor he stated the call lights are checked monthly and that the last date the shower call lights were checked was September 24, 2012.	F 463	inspections to ensure the deficient practice does not recur. Maintenance Supervisor, Administrator, DNS and DSD will conduct daily call-light checks to monitor performance to ensure solutions are sustained. The CQI Committee will review findings and evaluate for effectiveness during monthly CQI meetings.	11-16-12