11/22/13 POC accepted - Administrative withheld

DEPARTMENT OF HEALTH AND HUMA[illegible]ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

[redacted]

PRINTED: 11/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555143	A. BUILDING _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTLAND HOUSE	100 BARNET SEGAL LANE MONTEREY, CA 93940

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 10/21/13 through 10/24/13. The facility was licensed for 28 beds. The census at the time of the survey was 27 with no bed holds. The sample size was 10. Representing the California Department of Public Health: 30366, Health Facilities Evaluator Nurse; 27007 Health Facilities Evaluator Nurse; and 32999 Health Facilities Evaluator Nurse.	F 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH NOV 19 2013 L & C DIVISION SAN JOSE	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	1. Resident 4 was discharged on 11-5-13, Resident 5 was discharged on 10-25-13, Resident 6 was discharged on 11-1-13, Resident 7 was discharged on 10-30-13, Resident 8 was discharged on 10-24-13 from the facility. 2. Patients with orders for psychotropic medications will review informed consent prior to medication administration. 3. An informed consent form for psychotropic medications has been developed. See Attachment A 4. The informed conset paper work will be monitored daily for 30 days by the DON or	

LABO[redacted] (X6) DATE 11-18-13

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

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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156	designate for completeness, and then randomly. 5. The new form will be discussed with licensed staff at a staff meeting 11-21-13 and go into effect the following day 11-22-13.	11/22/13

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain informed consent for psychotropic medications for 5 of 10 sampled residents (4, 5, 6, 7, and 8). Findings: Review of the facility's 09/12 policy "Informed consent Ethics, Rights and Responsibilities" indicated it is the attending physician's responsibility to obtain the informed consent. It further indicated the informed consent form is prepared by the attending physician, and is discussed with the resident/family by the physician. The physician obtaining the consent, signs in the appropriate location. The nurse witnessing the signature of the resident signs as a witness. 1. Resident 4's clinical record was reviewed on	F 156		

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F 156	Continued From page 3 10/22/13. Her 10/20/13 physician orders indicated Resident 4 was to receive Lexapro (an antidepressant used to treat depression) 10 milligrams (mg) by mouth daily and Ativan (an antianxiety agent) 0.5 mg by mouth as needed for insomnia (an inability to fall asleep or to stay asleep) and anxiety. During an interview with director of staff development (DSD) on 10/22/13 at 8:10 a.m., she stated she obtained Resident 4's informed consent for use of Lexapro and Ativan on admission. She stated she explained to Resident 4 about the medications and those side effects. She further stated a licensed nurse on admission was supposed to obtain the informed consent for use of psychotherapeutic drugs. On the same day and time, during a review of Resident 4's Psychoactive Medication Informed Consent, dated 10/19/13 with DSD, she stated she filled out the form on Resident 4's admission. It indicated Resident 4 and DSD signed on the informed consent. There was no attending physician's signature. 2. Resident 5's clinical record was reviewed 10/21/13 and indicated she suffered from depression and insomnia. The attending physician at the transferring hospital ordered Lexapro 10 milligrams by mouth daily for depression. The attending physician also ordered Ambien 5 milligrams by mouth at bedtime for insomnia on an as-needed basis. The psychoactive medication informed consent form for Resident 5 dated 10/16/13 was signed by a staff licensed nurse, and not an MD as required by current regulations.	F 156		

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F 156	Continued From page 4 3. Resident 6's clinical record was reviewed 10/22/13 and indicated he suffered from depression. The attending physician at the transferring hospital ordered Desyrel 50 milligrams by mouth at bedtime and Celexa 20 milligrams by mouth daily. Both medications were for depression. There were two separate psychoactive medication informed consent forms. One for the Celexa, dated 10/12/13, and one for the Desyrel, dated 10/17/13. Both forms were signed by staff licensed nurses, not an MD as required by current regulations. 4. Resident 7's clinical record was reviewed 10/23/13 and indicated she suffered from depression and anxiety. The attending physician at the transferring hospital ordered Wellbutin XL 300 milligrams by mouth daily for depression. He also ordered Trazodone 300 milligrams by mouth at bedtime as a sedative/tranquilizer medication. To address the anxiety, the attending physician ordered Valium 5 milligrams by mouth every four hours as needed for anxiety. The psychoactive medication informed consent sheet dated 10/2/13 was signed by a licensed nurse, not an MD as required by current regulations. During an interview with licensed nurse A (LN A) on 10/23/13 at 9:28 a.m., she stated that the admitting registered nurses obtain all the medication information from the residents and discuss the use for, target symptoms and other information related to the psychotropic medications that the residents will be taking. LN A was asked to review Resident 7's psychoactive medication informed consent sheet and identify who signed it. LN A stated a registered nurse had signed it, and that the licensed nurses obtain the informed consent for the psychotropic	F 156		

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F 156	Continued From page 5 medications, not the physicians. 5. The clinical record for Resident 8 was reviewed on 10/23/13. Resident 8's Psychoactive Medication Informed Consent dated 10/14/13, showed recommendations to administer Ativan 0.5 mg by mouth or under the tongue daily as needed for agitation and Zyprexa 2.5 mg by mouth every six hours as need for agitation. The purpose the psychoactive medications were indicated for and the proposed course of the medications were blank. There was no attending physician signature on the consent.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 10 sampled residents (2) had interdisciplinary team (IDT) review to determine if the residents could safely self-administer drugs when a medication was found in the resident's possession. This has the potential for improper administration of medications. Findings: Review of the facility's policy "Self-Administration of Medications" dated 9/12 indicated a specific order must be written by the physician, the medication shall be clearly labeled by the provider pharmacy and the medication shall, unless	F 176	1. Resident 2 was discharged on 11-8-13. 2. All Residents who self administer medications will have a written MD order. The medication will be clearly labeled and the medication will be properly locked in the resident's medication drawer. Resident self medication will be reviewed at IDG (Inter-disciplinary Work Group) for appropriateness of self administration. 3. Review of policy to licensed staff will occur. 4. The DON or designee will randomly monitor patients for self administration policy compliance.	

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F 176	Continued From page 6 otherwise ordered, be locked in the resident's medication draw. In addition, proper administration techniques will be reviewed by the licensed nurse. During the initial tour observation on 10/21/13 at 9:10 a.m., accompanied by the administrator, Resident 2 was sitting in her wheelchair, next to her bed. In front of her on her bedside table, was white nasal spray bottle. The spray bottle was labeled decongestant nasal spray. During a concurrent interview, Resident 2 stated she self-administered the nasal spray when she needed it. On 10/23/13 at 8:45 a.m., during a visit, Resident 2's decongestant nasal spray was observed inside a clear plastic bag on her bedside table. When Resident 2 was asked about the nasal spray, she stated she had used the nasal spray about two to three times since her admission to the facility. During an interview on 10/21/13 at 12:15 p.m., the director of nurses (DON) stated if a resident is adamant about self-administering their medications, then the Interdisciplinary Team (IDT) would assess her to self-administer the medication. The DON was unable to find any self-administering for medication assessment for Resident 2. During an interview on 10/23/13 at 11:00 a.m., licensed nurse A (LN A) stated she was unable to locate a physician's order for Resident 2's decongestant nasal spray medication. She stated if a resident has medication at their bedside, the licensed nurse needs to ask the reason the	F 176	5. The correction action will be completed on 11-21-13 at a staff meeting for licensed staff.	11/21/13

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F 176	Continued From page 7 resident is taking the medication, and how often they are taking the medication. LN A stated the physician would be called for an order to self-administer the medication. She was unable to locate an assessment or physician's order for Resident 2 to self-administer the decongestant nasal spray.	F 176		
F 203 SS=B	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203	1. Resident 10 (closed chart) was discharged on 9-10-13 from the facility. 2. Westland House has changed procedures of notifying residents of right to appeal discharge date during the admission process. See Attachment B. Procedure to begin 11-18-13. Contact information for California Dept of Public Health has been added to Discharge Order Plan and Instruction form 11-15-13. See Attachment C. 3. All staff that admit residents have been notified of new procedure 11-15-13. 4. New forms will replace old forms as of 11-18-13. Administrator responsible 5. All corrections will be complete by 11-21-13.	11/21/13

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F 203	Continued From page 8 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the discharge notice including a statement of resident's right to appeal the action to the State for one of 10 sampled residents (10). The facility also failed to provide the contact information for the California Department of Public Health (CDPH). Findings: Resident 10's closed clinical record (a record for a resident no longer residing in the facility) was reviewed on 10/23/13. A 9/9/13 Discharge Order Plan and Instructions indicated there was no statement related to resident's right to appeal to the state. It included a telephone number of the Joint Commission (a group that administers accreditation programs for hospitals). However, it	F 203		

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F 203	Continued From page 9 did not include the contact information for CDPH. During an interview with the discharge planner (DP) on 10/23/13 at 1:45 p.m., she stated the facility's discharge instructions did not include the statement of right to appeal, or the contact information for CDPH.	F 203		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to; 1) develop written abuse policies to appropriately screen and train employees to prevent abuse; 2) implement their abuse policies when the facility failed to notify CDPH of two allegations of abuse and failed to protect the residents during their investigations for two non-sampled residents (11 and 12). Findings: 1. The facility's abuse policies were reviewed on 10/22/13. The facility's undated policy "Preventing of abuse" indicated the policy implement the seven key components of the abuse prevention program: screening, training, prevention, identification, investigation, protection and reporting/response. Another facility undated policy "Abuse prevention program" indicated the facility had developed an	F 226	1. Resident 11 was discharged on 10-31-13 and Resident 12 was discharged on 8-14-13 from the facility. 2. Written abuse policy will be developed and reviewed with new hires annually. See Attachment D 3. Information will be communicated to staff verbally and a care plan will be initiated and maintained on suspected cases of abuse. 4. The Social Worker, DON, and Administrator will meet on all alleged issues of abuse. The incidents will be discussed weekly at IDG (Interdisciplinary Work Group) meetings. 5. The corrective action will be completed on 11-21-13 at a staff meeting with all staff involved attending.	11/21/13

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F 226	Continued From page 10 abuse prevention program that includes employee pre-hire screening and employee training. On 10/22/13 a review of abuse policies indicated there were no written policies to screen and train employees to prevent abuse. During an interview on 10/23/13 at 1:30 p.m., with the licensed clinical social worker (LCSW) who introduced herself as an abuse coordinator she stated she could not find written abuse policies related to employees' training. During an interview with the facility administrator (ADM) on 10/24/13 at 9 a.m., she also identified herself as the abuse coordinator. ADM reviewed the facility's abuse policies and was unable to locate a policy related to the screening of potential employees for abuse, prior to direct resident care. 2. The facility's alleged violation reports were reviewed on 10/23/13. A review of Resident 11's Report of Suspected Dependent Adult/Elder Abuse, dated 9/29/13, indicated a visitor at the facility, threatened Resident 11 saying Resident 11 would not get his dog back. The facility was asked not to allow the visitor to enter Resident 11's room. A review of 9/30/13 social worker progress notes indicated she reported the allegation of abuse to the ombudsman and Adult Protective Services (APS). No documentation was available to show CDPH was notified of the allegation. During an interview with LCSW on 10/24/13 at 2 p.m., she stated she did not report Resident 11's	F 226		

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F 226	Continued From page 11	F 226		

incident to CDPH because the ombudsman told her not to report to CDPH. She reviewed the clinical record and was unable to find any related documentation including how the facility protected the resident from the visitor. There was no nursing documentation or care plan related to the incident.

A review of the facility's 2/22/11 policy "Reporting abuse" indicated all alleged violations of abuse are to be reported to the Ombudsman and State of California, Department of Health. It further indicated if the incident occurred in the resident's home or community, Adult Protective Services would be notified.

On 10/23/12, during a review of a second incident, Resident 12's Report of Suspected Dependent Adult/Elder Abuse, dated 8/14/13, indicated a staff member overheard Resident 12 and her caregiver yelling at each other in Resident 12's room on 8/11/13.

During an interview with LCSW on 10/23/13 at 2 p.m., she stated she did not report this incident to CDPH. She stated she was not sure this incident was an abuse or not because Resident 12 had dementia (a term used to describe various symptoms of cognitive decline such as forgetfulness).

During an interview with LCSW on 10/24/13 at 10 a.m., she stated the caregiver who yelled at Resident 12 continued to care for Resident 12 for the remainder of her stay at the facility. She stated she did not follow-up on the incident. She was unable to find any follow-up documentation indicating how the facility protected the resident from the caregiver. There was no care plan

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F 226	Continued From page 12 related to the incident. The facility's 2/22/11 policy "Reporting abuse" indicated verbal abuse was defined as regardless of their age, ability to comprehend or disability. The facility's 2/22/11 policy "Protect resident during investigation" indicated the abuse prevention coordinator would develop a plan for the resident's protection. The plan developed for each resident would be specific to that person's need to be kept from abuse. The plan will be incorporated in the chart and become available as part of the plan of care.	F 226		
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 provide medically-related social services for two non-sampled residents (11 and 12). Social services failed to reassess residents for any psychosocial impact from the incidents. Social service also failed to implement policies to protect residents from the incidents of alleged abuse. Findings: 1. On 10/23/13 a review of Resident 11's Report of Suspected Dependent Adult/elder Abuse, dated 9/29/13, indicated a visitor to the facility	F 250	1. Resident 11 was discharged 10-31-13 and Resident 12 was discharged 8-14-13 from the facility. 2. When resident abuse is suspected or observed the staff will fill out SOC-341 and call/send to the Dept of Public Health, call Ombudsman, notify Social Worker, Administrator and the DON. 3. Information will be communicated to staff verbally and a care plan will be initiated and maintained on suspected cases of abuse.	

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F 250	Continued From page 13 threatened Resident 11 saying Resident 11 would not get his dog back. The facility was asked not to allow the visitor to enter Resident 11's room. On the same day a review of 9/30/13 social worker progress notes indicated Resident 11 became distressed concerning his dog. During an interview with the administrator (ADM) on 10/24/13 at 9 a.m., she reviewed Resident 11's clinical record and was unable to find documentation related to the incident. She stated there was no care plan to protect the resident from the visitor. She further stated social service did not follow-up the incident. During an interview with the licensed clinical social worker (LCSW) on 10/24/13 at 2 p.m., she reviewed the clinical record and was unable to find any related documentation including how the facility protected the resident from the visitor. There was no care plan related to the incident. There was no follow-up documented evidence indicating social service had followed up on Resident 11's psychosocial impact from the incident. 2. On 10/23/13 a review of Resident 12's Report of Suspected Dependent Adult/Elder Abuse, dated 8/14/13, indicated a staff overheard Resident 12 and her caregiver yelling at each other in the resident's room on 8/11/13. During an interview with LCSW on 10/24/13 at 10 a.m., she stated the caregiver who yelled at Resident 12 continued to care for Resident 12 for the remainder of her stay in the facility. She stated she did not go back to the resident and	F 250	4. The Social Worker, DON, and Administrator will meet on all alleged issues of abuse. The incidents will be discussed in the IDG (Interdisciplinary Work Group) weekly meetings and Social Worker will follow up on incident and maintain accurate documentation. 5. The corrective action will be completed on 11-21-13 at a staff meeting with all staff involved attending.	11/21/13

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F 250	Continued From page 14 she did not follow-up the incident saying "I dropped the ball". She was unable to find any follow-up documentation indicating how the facility protected the resident from the caregiver and how the facility monitored the resident's psychosocial impact from the incident. There was no care plan related to the incident.	F 250		
F 283 SS=C	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a discharge summary including a recapitulation of the stay (a summary of the resident's stay while in the facility) for one of 10 residents (10). The discharge summary is to ensure a communication of necessary information for the resident's continuing care. Findings: Resident 10's closed clinical record (a record for a resident no longer residing in the facility) was reviewed on 10/23/13. A 9/9/13 discharge order plan and instructions indicated it did not reflect any summary including when and why Resident 10 was admitted to the facility and what therapies the resident had received at the facility.	F 283	1. The resident reviewed was discharged 9-10-13 from the facility. 2. All residents are affected by this deficiency. The discharge form has been revised by adding a section for recapitulation of stay. 3. The discharge order plan and instructions form has been revised to include a recapitulation of the resident's stay so as to maintain continued care after discharge. See Attachment E 4. The discharge paperwork will be monitored daily for 30 days by the DON or designate for completeness and then randomly. 5. The new form will be discussed with licensed staff at a staff meeting 11-21-13 and go into effect the following day 11-22-13.	11/22/13

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F 283	Continued From page 15 During an interview with the discharge planner (DP) and the administrator (ADM) on 10/23/13 at 1:45 p.m., DP stated the facility did not provide a discharge summary with a recapitulation of the resident's stay. ADM stated the attending physician only signed on physician's orders and faxed back to the facility. Physicians do not write down the summary of resident's care during the stay in the facility. ADM confirmed the facility did not provide a discharge summary including a recapitulation of the resident's stay.	F 283		
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 failed provide the necessary care and services for two of 10 sampled Residents (2 and 8). For Resident 2, the facility failed to obtain physician's orders for the use of her Cpap (continuous positive airway pressure, a machine used to treat sleep apnea) machine and treatment orders for her back incision. For Resident 8, the facility failed to obtain specific physician orders for his hyperbaric treatments and failed to coordinate care with the hyperbaric provider. Findings:	F 309	1. Resident 2 was discharged 11-8-13 from the facility. Resident 8 was discharged 10-24-13 from the facility. 2. The physician will be called for clarification of treatments if original order does not contain specific information for continuation of care. 3. The admission of staff member will review all orders and call the physician for clarification. 4. The admission orders will be audited the following AM for completeness by the DON or designate. If follow through is not maintained by admission staff, disciplinary action will begin.	

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F 309	Continued From page 16 Review of the facility's policy dated 9/12, titled "Initiation of Bipap/Cpap" showed if a resident uses a home unit, a physician's order is needed to state "resident may use own home Bipap/Cpap machine at current settings." Documentation will include the resident's oxygen saturation (oxygen level in the blood), respiratory rate, presence of snoring, presence of mask leak, presence of oral leak and paradoxical breathing. 1. Clinical record review for Resident 2 was initiated on 10/21/13. During the initial tour observation on 10/21/13 at 9:10 a.m., a Cpap machine was on Resident 2's bedside table. On 10/21/13 at 4:30 a.m., a facsimile (FAX) was sent to Resident 2's physician showing the resident has a Cpap machine and the facility requested a physician's order for Resident 2 to use the Cpap machine while at the facility. On 10/22/13, Resident 2's physician signed the FAX and authorized Resident 2 to use her Cpap machine while at the facility. Review of Resident 2's care plan problem dated 10/20/13, to address her diagnosis of sleep apnea, showed an intervention dated 10/23/13, for the authorization of Resident 2 to use the Cpap machine. Review of Resident 2's Progress Notes dated 10/20/13 at 11:00 p.m., showed her Cpap machine was set up. Resident 2's Progress Notes dated 10/21/13 at 2:00 a.m. documented the resident was using the Cpap machine.	F 309	5. The procedural change will take effect 11-22-13 following the staff meeting on 11-21-13.	11/22/13

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F 309	Continued From page 17 Review of Resident 2's Treatment Record showed no documentation for the use of her Cpap machine During an interview on 10/23/13 at 11:00 a.m., licensed nurse (LN) A stated Resident 2's physician should have been called to obtain an order for the use of Resident 2's Cpap machine. She was unaware of the reason Resident 2 was using the Cpap machine one day prior to the physician's order. Review of Resident 2's Resident Assessment-Data Collection Form dated 10/20/13, showed she has a back incision with steri-strips (strips to close an opening in the skin), open to air. Review of Resident 2's Treatment Record showed no documentation for the monitoring or treatment of her back incision. During an interview on 10/22/13 at 7:00 a.m., LN C stated a resident's wound treatment would be documented on the treatment record and would be kept behind the resident's medication administration record (MAR). She was unable to locate a treatment for Resident 2's back incision. During an interview on 10/23/13 at 11:00 a.m., LN A confirmed Resident 2 had a back incision. She was unable to locate a physician's order for wound treatment. LN A stated a physician's order should have been obtained. 2. Clinical record review for Resident 8 was initiated on 10/23/13. Resident 8 was admitted to the facility with diagnoses including skin necrosis (death of cells or tissue due to injury or disease)	F 309		

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F 309	Continued From page 18 of his right lower leg. Review of the facility's Admission Worksheet dated 10/14/13, showed Resident 8's initial plan of care was to continue his right leg's hyperbaric treatments on 10/16/13, 10/17/13, 10/18/13, 10/21/13 and 10/22/13. Review of Resident 8's hospital's transfer orders dated 10/14/13, showed he required hyperbaric treatments to his right leg. Review of Resident 8's Progress Notes dated 10/16/13, 10/18/13, and 10/22/13, showed Resident 8 left the facility for his hyperbaric treatments. Review of Resident 8's Treatment Record for October, 2013, documented Resident 8's family member was to pick up the resident at 9:00 a.m., for hyperbaric treatments. No coordination of care was available with the hyperbaric department in Resident 8's clinical record. No physician's order was available to show the name, location, or telephone number of the hyperbaric department, or the specific dates, times and method of transportation of his hyperbaric treatments. During an interview on 10/23/13 at 11:10 a.m., licensed nurse A confirmed Resident 8's physician orders were not specific for his hyperbaric treatment and no coordination of care was available from the hyperbaric department.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	1. Resident 4 discharged on 11-5-13, Resident 5 discharged on 10-25-13,	

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F 329	Continued From page 19 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to initiate non-pharmacological interventions, perform adequate behavior monitoring, and monitor for adverse side effects of psychotropic medications for 5 of 10 sampled residents (4, 5, 6, 7, and 8). This had the potential of adverse consequences in residents. Findings: 1. Resident 4's clinical record was reviewed on 10/22/13. Her 10/20/13 physician orders indicated	F 329	Resident 6 discharged on 11-1-13, Resident 7 discharged on 10-30-13, and Resident 8 discharged on 10-24-13 from the facility. 2. Medications on admission will be reviewed by the DON or designate for proper documentation of ordered anti-psychotic medications. This was initiated 11-12-13. 3. To ensure that proper documentation of anti-psychotic medications and their side effects are reviewed with licensed staff an inservice by the pharmacy consultant will be scheduled. 4. The DON or designate will monitor all psychotropic drug records for one month and then randomly every month. 5. This corrective measure was started on 11-12-13 and will be an ongoing practice at the facility.	11/12/13

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F 329	Continued From page 20 Resident 4 was to receive Lexapro (an antidepressant used to treat depression) 10 milligrams (mg) by mouth daily and Ativan (an antianxiety agent) 0.5 mg by mouth as needed for insomnia (an inability to fall asleep or to stay asleep) and anxiety. A review of 10/13 Psychotropic Drug Record indicated symptom/behavior for use of Lexapro remained blank. During an interview with the director of staff development (DSD) on 10/22/13 at 8:10 a.m., she reviewed the clinical record and was unable to find documentation indicating Resident 4's mood or behaviors. She stated Lexapro was resumed at the facility because she had been on the medication prior to the admission. DSD was unable to answer what behaviors manifested of Resident 4's depression or anxiety. The facility's 09/12 policy "Psychotropic medication use" indicated the resident's need for the psychotropic medication will be monitored. It further indicated before administering the medications, the nurse must review the medication, specific target behavior with the resident or resident's representative. 2. Clinical record review for Resident 5 was conducted 10/21/13. Resident 5's psychoactive medication informed consent form indicated that Ambien was ordered for insomnia as the specific condition/diagnosis. The indicated beneficial effect expected was good night's sleep. The form listed Lexapro for depression as the specific condition/diagnosis with no target behaviors/symptoms. The beneficial effect expected was for cheerfulness. Review of	F 329		

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F 329	Continued From page 21 medication administration records, nursing notes and care plans did not indicate any outcomes of either positive or negative benefits of these two medications. There was no indication anywhere in the record that the side effects for either medication was being monitored. 3. Clinical record review for Resident 6 was conducted 10/22/13. Resident 6's psychoactive medication informed consent form indicated that Trazodone was ordered for depression as the specific condition/diagnosis with no target behaviors/symptoms. There were no beneficial effects expected indicated. There was no indication anywhere in the record the side effects were being monitored. Celexa was also ordered for depression. The psychoactive medication informed consent form did not indicate beneficial effects expected or target behaviors/symptoms. There was no indication in the record any side effects were being monitored. Clinical record review for Resident 7 was conducted on 10/23/13. Resident 7's psychoactive medication informed consent form indicated Wellbutrin and Trazodone for depression without any target symptoms or behavior. There was no indication of beneficial effects expected. There was no indication in the record that any side effects were being monitored. 4. Review of Lexicomp Online (Web based Internet site) showed Ativan (anti-anxiety medication) is used for management of anxiety disorders and relief of anxiety symptoms. This medication is considered to potentially inappropriate for the geriatric population. Monitoring parameters should include symptoms	F 329		

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F 329	Continued From page 22 of anxiety. Review of Lexicomp Online showed Zyprexa (anti-psychotic medication) is used for the treatment of schizophrenia, mania episodes associated with bipolar disorder or with agitation related to Alzheimer's dementia. This medication is considered to potentially inappropriate for the geriatric population. Clinical record review for Resident 8 was initiated on 10/23/13. Review of Resident 8's Medication Administration Sheets documented orders to administer Ativan 0.5 milligrams (mg) by mouth or under the tongue as needed for anxiety, one dose daily prior to hyperbaric treatment only, as needed and to administer Zyprexa 2.5 mg every six hours as needed for agitation. Review of Resident 8's Psychotropic Drug Record for the administration of Ativan, showed on 10/16/13 at 8:50 a.m., Ativan 0.5 mg was given for anxiety before he left for his hyperbaric treatment. No response to the medication/behaviors were monitored. No documentation was available to show examples of what least restrictive non-drug measures were attempted and found to be ineffective, prior to the psychoactive medications. No diagnoses or behaviors were indicated for the administration of the medications. In addition, no monitoring of the behaviors were available. During an interview on 10/23/13 at 11:10 a.m., licensed nurse (LN) A stated she was unable to locate behavior monitoring for Resident 8's use of	F 329		

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F 329	Continued From page 23 Ativan or Zyprexa. She stated she had not witnessed any anxiety behavior from Resident 8. LN A stated "I have to give it (Ativan) prior to [Resident 8's] hyperbaric treatment, because that is what his [family member] said."	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	1. Clarification of daily nursing staffing will be posted in a prominent place accessible to staff, residents, and visitors. 2. The NHPPD will be posted in a prominent area accessible to staff, residents, family, and visitors. 3. The nursing assignment sheet has been revised to include total nursing hours and daily census. The new form has been reviewed with staff on 11-13-13. See Attachment F 4. The nursing assignment sheet will be reviewed and signed daily by the DON or designate. 5. The DON will have met individually with all charge staff to explain function of new staffing form. This will be completed by 11-14-13.	11/14/13

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F 356	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the daily nurse staffing data in a prominent place readily accessible to residents and visitors. Findings: During the facility tour on 10/20/13 and 10/21/13, the nurse staffing hours were not visible in the facility. During an interview on 10/23/13 at 10:00 a.m., the administrator (ADM) stated she had never posted the facility's hours per resident day reports. The ADM stated only the staff names and room assignments were posted. She stated she was unaware the staffing hours needed to be posted.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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.	F 431	1. Suppositories that do not require refrigeration per manufacturer has been moved to medication cart on 10-25-13. 2. Clinical staff will be inserviced on 11-21-13 regarding reading manufacturers recommendation. 3. Pharmacy consultant will check for suppositories stored in refrigerator monthly at pharmacy review and will notify DON immediately.	11/21/13

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(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 431	Continued From page 25 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 manufacturer's recommendations, the facility failed to ensure medications were stored properly in two of two medication refrigerators. Multiple suppositories were not stored per the manufacturers' recommendations. This has the potential to affect the integrity of the medications. In addition, a unlocked, unattended medicine cart was left in the hallway. Findings: Review of the facility's policy dated 9/12, "Drug procurement/storage/inspection" documented medication carts will be locked when not attended. 1. During a medication room inspection conducted on 10/22/13 at 1:30 p.m. on the McCone nursing unit with licensed nurse D (LN D), one box of Dulcolax suppositories was	F 431	4. DON and Administrator will monitor pharmacy review monthly. DON will do random checks of refrigerated medications and manufacturers recommendations. 5. Corrective measures have been completed on 10-25-13. All clinical staff will be made aware on 11-21-13 at staff meeting. DON/Administrator responsible 1. LN A was counseled on locking med cart when not attending the cart. She understands rationale to do so. 2. At inservice on 11-21-13 standard to lock med cart when not attended to will be discussed. 3. Staff will be made aware of importance of locking med cart progressive discipline will be used for clinical staff that do not adhere to this policy. 4. DON or designee will continue to monitor for unlocked medication carts during rounds.	11/21/13 11/21/13

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F 431	Continued From page 26 observed stored in the refrigerator door. Storage instructions on the box indicated to store at room temperature. During an interview with LN D on 10/23/13 at 9:45 a.m. regarding the refrigerated Dulcolax suppositories, LN D stated after reading the instructions on the box, the medication was to be stored at room temperature. During a medication room inspection (Hermann wing) on 10/22/13 at 1:40 p.m., accompanied by licensed nurse B (LN B), two boxes containing a total of 81 Dulcolax suppositories were stored in the medication refrigerator. The manufacturer's recommendation listed on the box stated to store the suppositories at room temperature. The thermometer in the medication refrigerator read 41 degrees. On 10/22/13 at 1:40 p.m., an interview with LN B was conducted. He stated he was unaware of the manufacturer's recommendations for the Dulcolax suppositories and removed the boxes from the refrigerator. 2. During medication pass observation on 10/22/13 at 8:11 a.m., LN A poured Resident 7's medications and entered the resident's room without locking the medication cart. The unlocked, unattended medicine cart was observed in the hallway. On 10/22/13 at 1:50 p.m., an interview was conducted with LN A. She stated the medication cart should have been locked when unattended.	F 431	5. Inservice of clinical staff will be completed 11-21-13. DON/Designee responsible	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 27 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	1. This requirement has the potential to affect all residents at the facility. 2. All residents are monitored for infections. Some are admitted from acute care on antibiotics and at times some are started on antibiotics while a resident. The type of infections are evaluated by the physician and appropriate measures of treatment are ordered. 3. The DON will continue to do surveillance for HAI's and forward documentation to the Infection Control Coordinator. This paperwork will be sent as soon as information has been gathered. See Attachments G & H 4. The Infection Control Director and the DON have scheduled meetings monthly and will communicate earlier if necessary. The documentation will be maintained in the Infection Control binder and updated in a timely manner.	

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F 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility documentation, the facility failed to maintain an effective, infection control program when they failed to collect complete epidemiologically (diseases) data for August and September 2013. This poses the risk of the facility failing to identify infections and take appropriate steps to prevent the spread of infections throughout the facility. Also, during a medication pass observation, the licensed nurse failed to ensure infection control techniques were maintained during medication administration of two sampled (3 and 7) and one non-sampled (13) residents. Findings: The facility was unable to provide a policy related to surveillance of infections, related to the collection of data and mapping or trending of infections. 1. Review of the facility's Infection Control Program for August, 2013, had eight individual sheets titled "Report of Possible Infection," (five residents were identified to have infections upon admission to the facility, two residents were identified as developing infections 48 hours or more after their admission and one resident was identified as receiving an antibiotic to prevent a urinary tract infection upon admission). No culture and sensitivity reports were available for the August, 2013 Infection Control Program with identified infections. No line listing for August was available. No documentation were available to identify if a resident was placed on isolation. No map or trending was available. No documentation was available to show when the	F 441	5. Corrective action is going to be ongoing beginning December 2013 with the monthly meeting between Infection Control Coordinator and DON.	

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F 441	Continued From page 29 residents were cleared from infection. In addition, review of the facility's Third Quarter 2013 Infection Control Report only identified the number of resident days. No documentation was available to show the percentage of resident infections. Review of the facility's Infection Control Program for September, 2013, had eight individual sheets titled "Report of Possible Infection." Six residents were identified to have infections upon admission to the facility, and two residents were identified as developing infections 48 hours or more after their admission (one resident with a wound infection, and one resident with a Clostridium difficile (diarrhea)). No line listing for September was available. No documentation were available to identify if a resident was placed on isolation. No map or trending was available. No documentation was available to show when the residents were cleared from infection. On 10/23/13 at 10:30 a.m., an interview was conducted with the administrator. She stated the director of nurses is the Infection Control Designee. When asked if the facility had documentation of an individual line listing, cumulative monthly line listing or mapping and trending, the administrator stated "No." When the administrator was asked about the residents' culture and sensitivity (C&S) reports, she stated if a resident had a C&S test, the results would be in the resident's individual chart. She stated the facility did not have a monthly C&S report from the laboratory. The administrator stated she was unaware of any mapping or trending of infections.	F 441		

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F 441	Continued From page 30 In addition, when the administrator was asked for resident infections from October 1 through October 23, 2013, she stated the reports were not done yet. She was unable to locate any documentation related to resident infections for October, 2013. 2. During medication pass observation on 10/22/13 at 8:11 a.m., licensed nurse A (LN A) was observed passing medications for two sampled residents (3 and 7) and one non-sampled resident (13). With her bare hands, she poked the underside of the punch cards with her finger to make a hole for the medications to be removed, touching the medications, then pushed the medications out of the hole. In addition, she put her finger inside the open medication containers, and dragged the medications out of the containers with her finger to place the medication on the underside of the top of the container, prior to pouring the medication into the medicine cup. a. For Resident 7, LN A poked six punch cards and inserted her finger inside three medication containers. b. For Resident 3, LN A poked four punch cards and inserted her finger inside two medication containers. c. For Resident 13, LN A poked five punch cards and inserted her finger inside three medication containers. During an interview on 10/22/13 at 1:50 p.m., LN A stated she should not have touched the residents' medications with her bare hands.	F 441		
F 514	483.75(l)(1) RES	F 514	1. Resident 1 discharged on 11-1-13, Resident 2	

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F 514 SS=D	Continued From page 31 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately document for ten of ten residents when the facility used physician transfer/home care orders as admitting orders. The facility also failed to complete fall assessment for two of 10 sampled residents (3 and 4). Findings: 1. The clinical record for Resident 1 was reviewed on 10/21/13. The record included a 10/2013 Physician SNF (skilled nursing facility) Transfer/Home Care document along with an Active Medications list from the acute care hospital. The forms included code status, diagnosis, diet, and recommended therapy treatments. No skilled nursing physician admission orders were available in Resident 1's clinical record. The clinical record review for Resident 2 was	F 514	discharged on 11-8-13, Resident 3 discharged on 10-23-13, Resident 4 discharged on 11-5-13, Resident 5 discharged on 10-25-13, Resident 6 discharged on 11-1-13, Resident 7 discharged on 10-30-13, Resident 8 discharged on 10-24-13, Resident 9 discharged on 10-25-13, and Resident 10 was a closed chart that discharged on 9-10-13 from the facility. 2. Form sent from hospital has been reviewed and policy will be written and followed regarding signature of accepting skilled nursing physician. 3. Policy change by 11-20-13 DON/Administrator responsible 4. Admission/Discharge person will ensure accepting skilled nursing facility physician's signature is present before admission to Westland House DON/Designee will monitor for accuracy. DON responsible	11/20/13

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F 514	Continued From page 32 initiated on 10/21/13. The record included a Physician SNF Transfer/Home Care document along with an Active Medication list from the acute care hospital dated 10/2013. The forms included diagnosis, code status, activity, diet and recommended therapy treatments. No skilled nursing physician admission orders were available in Resident 2's clinical record. The clinical record for Resident 3 was reviewed on 10/21/13. The record included a Physician SNF Transfer/Home Care document along with an Active Medication list from the acute care hospital dated 10/2013. It included code status, diet, therapy, activity and consult. No skilled nursing physician admission orders were available in Resident 3's clinical record. Resident 4's clinical record was reviewed on 10/22/13. The record included a Physician SNF Transfer/Home Care document along with an Active Medication list from the acute care hospital. It included code status, activity, diet, dietary supplement, therapy and consultation. No skilled nursing physician admission orders were available in Resident 4's clinical record. Resident 5's clinical record was reviewed on 10/21/13. The record included a 10/2013 Physician SNF Transfer/Home Care document along with an Active Medication list from the acute care hospital. It included code status activity, diet and therapy recommendations. No skilled nursing physician orders were available in Resident 5's clinical record. Resident 6's clinical record was reviewed on 10/22/13. The record included a 10/2013 Physician SNF Transfer/Home Care document	F 514	5. Clinical staff along with Admission/Discharge staff member will be inserviced on proper procedure by 11-21-13. 1. Resident 4 was discharged on 11-5-13. 2. LN E was counseled on incomplete falls assessment score on 10-28-13. 3. Clinical staff will be inserviced on importance of completing all documents related to the resident on 11-21-13. 4. Monitoring of falls risk assessment has been added to auditors checklist. Auditor will check daily for completeness of falls risk assessment. If incomplete staff member will bring it to the attention of DON/Designee who will speak to clinical staff member. 5. All clinical staff members responsible for task of completing falls risk assessment sheet will be inserviced on 11-21-13. DON responsible	11/21/13

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F 514	Continued From page 33 along with an Active Medication list from the acute care hospital. It included diagnosis, code status, activity, diet, and therapy recommendations. No skilled nursing physician orders were available in Resident 6's clinical record. Resident 7's clinical record was reviewed on 10/23/13. The record included a 10/2013 Physician SNF Transfer/Home Care document along with an Active Medication list from the acute care hospital. It included diagnosis, code status, diet and therapy recommendations. No skilled nursing physician orders were available in Resident 7's clinical record. Resident 8's clinical record was reviewed on 10/23/13. The record included a 10/2013 Physician SNF Transfer/Home Care document along with an Active Medication list from the acute care hospital. It included diagnosis, code status, diet and dressing change instructions. No skilled nursing physician admission orders were available in Resident 8's clinical record. Resident 9's clinical record was reviewed on 10/23/13. The record included a Physician SNF Transfer/Home Care document along with an Active medication list from the acute care hospital. It included diagnosis, code status, diet and dressing change instructions. No skilled nursing physician admission orders were available in Resident 9's clinical record. The clinical record for Resident 10 was reviewed on 10/23/13. it included a 9/2013 A review of 9/1/13 Physician SNF Transfer/Home Care document along with a Active Medication list from the acute care hospital. It included code status,	F 514		

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F 514	Continued From page 34 diet, therapy, activity and therapy recommendations. No skilled nursing physician admission orders were available in Resident 10's clinical record During an interview on 10/21/13 at 11:50 a.m., licensed nurse E (LN E) stated the facility used the discharge/transfer physician's orders from the hospital as the skilled nursing facility admission orders. She stated the physicians would place their initials in the box next to the medications on the transfer orders for medications the resident was to continue while at the facility. LN E stated the nurses do not rewrite the transfer orders as admission orders. 2. The clinical record for Resident 3 was reviewed on 10/21/13. A review of 10/1/13 discharge summary from an acute care hospital indicated Resident 3 had hypertension and two falls at home. Resident 3 sustained a fracture on left lower leg from the fall incident. On the same day, a review of Resident 3's 10/1/13 Fall Risk Assessment indicated the assessment was incomplete. Assessment of blood pressure and total fall risk score remained blank. The clinical record for Resident 4 was reviewed on 10/22/13. A review of 10/15/13 discharge summary from an acute care hospital indicated Resident 4 had multiple falls at home and prior to the admission, had a surgery of revision of left hip placement (a procedure in which the surgeon removes damaged or diseased parts of the hip joint and replaces them with new artificial parts). On the same day, a review of Resident 4's	F 514		

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F 514	Continued From page 35 10/19/13 Fall Risk Assessment indicated the assessment was incomplete. The resident's medication assessment and total fall risk score remained blank. During an interview with the director of staff development (DSD) on 10/22/13 at 8:10 a.m., she stated both fall assessments for Resident 3 and Resident 4 were incomplete. She stated admitting nurses assessed a new resident's fall risks and night shift nurses audited the new resident's fall assessment for completeness. She further stated she did not know why both fall assessments were incomplete. A review of the facility's 09/12 policy "Fall prevention guidelines" indicated all residents will be assessed on admission using the fall assessment guidelines to prevent falls.	F 514		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation, the facility failed to train employees in emergency procedures. Seven of eight staff members interviewed were unaware of the location of emergency food and they were not aware how long the facility would provide the emergency food and water. This has the potential	F 518	1. ES 1 (and all environmental service workers) were shown again what the emergency closet contained. ES worker was also shown where emergency food was stored. It was also clarified that we have 3 days of food and 4 days of water. 2. All staff at Westland House will be inserviced on where emergency food, water, and supplies are kept and how many days they will last. Inservice will be 11-21-13.	11/21/13

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F 518	Continued From page 36 for a delay in response in the event of a fire or earthquake. Findings: The facility's 8/30/00 policy "Nutrition service emergency preparedness management program" indicated the emergency foods are located in the pantry (inside kitchen). The emergency water source include bottled water stored in the emergency closet. It further stated the facility provides emergency food for 3 days and provides emergency water for 4 days. During an interview with an environmental service staff (ES 1) on 10/22/13 at 9 a.m., he stated emergency food was stored in a room back in the hallway and food would be provided for 4 months. During an interview with certified nursing assistant (CNA 1) on 10/22/13 at 9:15 a.m., she stated emergency water and food were stored together in the room. She was not aware how long the emergency food and water would be supplied. During an interview with licensed nurse A (LN A) on 10/22/13 at 1:20 p.m., she stated emergency food and water were stored together in the emergency supply room in a hallway. During an interview with the director of rehabilitation (DOR) on 10/23/13 at 8:50 a.m., she stated emergency water and food were stored together in an emergency supply room. She stated water and food would be provided for 2 weeks. During an interview with physical therapist 2 (PT 2) on 10/23/13 at 9 a.m., she stated emergency food and water were stored together in the room	F 518	3. Poster was hung on emergency closet stating above mentioned facts. 4. Rehab Supervisor or designee will script a short quiz on where emergency supplies are kept and how long the supplies will last. Quiz will be collected by Rehab Supervisor or designee, graded and kept on file. This exercise will be completed by 11-21-13, and will be reviewed annually at staff meetings. Rehab Supervisor/ Administrator responsible	

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F 518	Continued From page 37 back in the hallway and she was not aware for how long those would last. During an interview with activity staff 1 (AS 1) on 10/23/13 at 9:20 a.m., she stated emergency water and food were stored in emergency storage room together and would be provided for 5 days. During an interview with occupational therapist 2 (OT 2) on 10/23/13 at 9:35 a.m., he stated emergency food and water were stored together in the room in a hallway.	F 518		11/21/13