STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055145	A. BUILDING _____ B. WING _____	11/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH VALLEY NURSING CENTER poc reviewed by yk on Dec, 23/2011, at 8:20 AM.	7660 WYNGATE ST TUJUNGA, CA 91042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification Survey. Representing the Department of Public Health: [redacted], RN- HFEN [redacted], RN- HFEN [redacted], RN-HFEN [redacted] RN-HFEN Total Population: 78 Sample Size: 16 Highest S/S = E	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal or state law.	
F 152 SS=D	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the social service helped the resident who was mentally incompetent to apply for a conservatorship or	F 152	Public Guardianship is being applied for the patient by the Social Service Designee (SSD). The SSD will review the status of the other patients in the facility and apply for Public Guardianship and/or Conservatorship as appropriate. The Administrator will monitor for compliance. Issues of non-compliance will be presented to the Quality Assurance Committee for resolution.	2011 DEC 23 AM 8:36 12/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/22/11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 152	Continued From page 1 public guardian appointed by the court for one out of 17 sample residents (6). Findings: On November 16, 2011, between 8:40 a.m. to 9:30 a.m., during the initial tour observation, the resident was observed lying in bed attached to the mechanical ventilator. According to the admission record, the resident was admitted on June 15, 1999, with diagnoses that included persistent vegetative state and attention to tracheostomy and gastrostomy. The resident did not have any family, responsible party or emergency contact listed in the admission record. The surrogate decision maker is the skilled nursing facility. The quarterly Minimum Data Set (MDS) assessment dated September 12, 2011, indicated the resident was comatose. A review of the Social Services Assessment dated September 12, 2011, indicated the resident was married but her husband was also a resident in another SNF home and he was unable to provide any support due to his medical/mental status. Spouse cannot visit and there are no other family members available. A review of the clinical record revealed there was no documented evidence that public guardianship or conservatorship was applied for the resident. On November 16, 2011, at 10:55 a.m., during an interview with the Social Service Director, she stated the interdisciplinary team (IDT) was	F 152		

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F 152	Continued From page 2 responsible for the resident. She stated she had not tried to apply for public guardianship or conservatorship. The facility's policy and procedure titled "Social Services" dated September 2005, indicated the facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychological well-being. The social services department is responsible for making referrals to social service agencies as necessary or appropriate, maintaining appropriate documentation of referrals and providing social service data summaries to such agencies.	F 152		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	The curtains were appropriately closed when the deficient practice was identified. All nursing staff will be in-serviced by the Director Of Staff Development (DSD) concerning personal privacy. The Administrator, Director of Nursing (DON), Assistant DON (ADON), DSD and RN Supervisors will monitor daily for compliance. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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F 164	Continued From page 3	F 164		

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure a resident was provided visual privacy while a licensed nurse administered medications through a gastrostomy tube (11), and to ensure that a resident was not exposed to others while the resident was taking a shower for one random observation, and one out of 16 sample residents (11).

Findings:

a. On November 17, 2011, at 8:05 a.m. during medication pass observation, Registered Nurse 4 (RN 4), did not draw the resident's privacy curtain while she administered medications through the resident's gastrostomy tube. The resident was exposed to the room mate.

On the same date at 8:25 a.m., RN 4 during an interview stated she should have closed the privacy curtain all the way.

b. On November 18, 2011, at 9 a.m. during a tour with the maintenance supervisor, the shower door next to Room 20 was observed wide open. A shower curtain inside of the shower room was not fully drawn, exposing the thigh and hip area of a

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F 164	Continued From page 4 resident's naked body. A staff member was providing a shower to the resident who was sitting in a shower chair. A review of the facility's policy of the Bodily Privacy during Care and Treatment indicated the staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. During an interview with the maintenance supervisor at this time, he stated the reason the staff kept the shower room door open was because it was easier to give residents a shower due to lack of space. He stated the door should have been closed.	F 164		
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 ensure a resident had a physician order for a dental consult for one out of 16 sample residents (5). Findings: a. According to the admission record, Resident 5 was readmitted to the facility on January 21,	F 250	The SSD has scheduled a dental consult for the patient. The SSD will review the status of all patients in the facility and schedule consults as warranted. The Administrator and SsD Consultant will monitor for compliance. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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F 250	Continued From page 5 2011, with diagnoses that included Diabetes Mellitus, organic brain syndrome, and anemia. The resident had a physician's order dated October 17, 2011, for the dental consult as indicated. However, there was no documented evidence that indicated the dental consult was implemented and a review of the resident's clinical record did not indicate the social service staff member had arranged a dental visit for the resident. On November 17, 2011, at 3:20 p.m. during an interview with the social service designee, she stated the dental consultation should have been done. However, she was not able to provide the documented evidence for the referral that was made for the dental consultation. During an interview with Registered Nurse 2 at the same time, she was not able to provide documentation the staff had communicated regarding the physician's order, therefore the physician's order was relayed to the social service designee.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278	The nurse assigned to completing the Minimum Data Set (MDS Nurse) modified the MDS when the deficient practice was identified. The DON, ADON and MDS Nurse will review the MDS of all patients quarterly and on change of condition to assure compliance. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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F 278	Continued From page 6 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident's assessment information related to functional ability to dress (3) and to participation in assessment and goal setting (6) were accurately assessed and recorded on the Minimum Data Set (MDS) to reflect the actual health status of each resident for two out of 16 sample residents (3,6). Findings: a. According to the admission record, Resident 3 was admitted to the facility on January 11, 2001, with diagnoses that included quadriplegia and diabetes. The MDS assessment dated February 2, 2011, indicated the resident's ability was coded as independent in dressing.	F 278		

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F 278	Continued From page 7	F 278		

On November 16, 2011, at 2:40 p.m. during an interview with Registered Nurse 3, she stated the MDS assessment dated February 2, 2011, was coded incorrectly and should have been coded as totally dependent on the staff and needed two person's assistance in dressing.
b. On November 16, 2011, between 8:40 a.m. to 9:30 a.m., during the initial tour observation, Resident 6 was observed lying in bed and the resident was on a mechanical ventilator for breathing.

According to the admission record, Resident 6 was admitted to the facility on June 15, 1999, with diagnoses that included persistent vegetative state, tracheostomy and gastrostomy. The resident did not have a family member as responsible party or a representative listed in the clinical record for emergency contact. The surrogate decision maker is the skilled nursing facility.

The quarterly review Minimum Data Set (MDS) assessment dated December 12, 2010, indicated the resident was comatose. Under Section Q, Participation in Assessment and Goal Setting, indicated the the resident had no guardian or legally authorized representative participated in assessment. However, a portion of the MDS assessment under Section Q was recorded inaccurately as "Yes" to indicate the resident had family or significant others when in fact, the resident did not had a guardian or legally authorized representative.

On November 16, 2011, at 10:55 a.m., during an interview with Registered Nurse 3 (RN 3), she

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F 278	Continued From page 8 stated she should have coded the MDS accurately. According to RN 3, the part of the coding under Section Q was inaccurate because she used the social service notes only. She also stated they do not have a policy and procedure for the MDS. According to the facility's guideline on the Resident Assessment Instrument (RAI) dated December 2002 (Briggs Enhanced - MDS version 2.0 User's Manual), indicated the importance of accurately completing and submitting the MDS cannot be overemphasized. Primary responsibility for accuracy lies with the person selecting the MDS item response. In addition, the RN coordinating the assessment must sign and date the MDS. The signature of the RN attests to the completeness of the document.	F 278		
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 a record review, observation and interview, the facility failed to identify the set rate of a pacemaker and monitor the condition to ensure the device was functioning to effectively regulate the resident's heart rate and to include interventions in the event of a pacemaker	F 309	The set rate for the patient's pacemaker was obtained so that it can be properly monitored. The DON and ADON will identify any other patients with pacemakers to assure that they are properly monitored. The DON and ADON will monitor all new admissions to assure that patients with pacemakers are properly monitored. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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F 309	Continued From page 9 malfunctions for one out of 16 sample residents (8). Findings: According to the admission record, Resident 8 was readmitted on October 21, 2011, with diagnoses that included status cardiac pacemaker, cardiac dysrhythmia and hypertension. The Minimum Data Set (MDS) assessment dated April 26, 2011, indicated the resident was [redacted] for daily decision making, needed total dependence from staff members for transfer, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. On November 16, 2011, at 4 p.m., during an observation, the resident was attached to the ventilator and was sleeping. The resident was observed to have a pacemaker on the left side of the chest. There was a plan of care dated October 21, 2011, for potential for decreased cardiac output, chest pain, dizziness due to pacemaker and potential for pacemaker malfunction. The care plan had a goal for the resident's heart beat will be maintained within normal limits (60 to 80 beats per minute) daily. The approach plan included monitor and report any signs and symptoms of irregular heart rate, chest discomfort, and complaint of dizziness. However, there was no information related to the type and the set rate of the pacemaker in order to monitor the effective functioning of the device.	F 309		

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F 309	Continued From page 10 On November 17, 2011, at 1:15 p.m., during an interview, Registered Nurse 6 (RN 6), stated the pacemaker settings should have been included in the clinical record and in the plan of care. The facility's policy and procedure titled "Pacemaker Monitoring", indicated the purpose of monitoring a resident with a permanent pacemaker is to ensure any abnormal heart rate is identified as soon as possible. If known, the pacemaker type, set rate, and insertion date will be documented in the clinical record on the care plan. However, there was no documented evidence that the facility staff tried to obtain the pacemaker setting information.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility's licensed staff who administered medications through a gastrostomy tube (GT) failed to check the GT placement and the gastric residual volume (bedside assessment to measure the gastric volume used in the	F 322	The licensed nurse corrected the deficient practice when it was identified. All licensed nurses will be in-serviced by the DON concerning proper procedure for medication administration through the gastric tube. The DON, ADON, DSD and RN Supervisors will monitor daily for compliance. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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F 322	Continued From page 11 prediction of aspiration) and ensure that the volume was not high or "too much" in order to prevent the potential for aspiration for one out of 16 sample residents (11). Findings: According to the admission record, Resident 11 was admitted to the facility on August 15, 2011, with diagnoses that included dysphagia (difficulty swallowing), and gastrostomy. The Minimum Data Set (MDS) assessment dated August 24, 2011, indicated the resident was [redacted] for daily decision making, needed total assistance from the staff for the activities of daily living, and feeding tube was used for the nutrition. The resident had a physician's order dated August 15, 2011, to check tube placement and to check gastric residual volume. There was a plan of care developed on August 15, 2011, for dysphagia and GT placement. One of the approach in the care plan was to check placement and residual every shift. On November 17, 2011, at 8:05 a.m. during Resident 11's medication pass observation via GT for by Registered Nurse 4, (RN 4) did not check the gastrostomy tube placement and the gastric residual volume prior to flushing the GT with water. After RN 4 flushed the GT with 60 cc's of water, she realized that she did not check the GT placement and RN 3 checked the placement and administered four different kinds of medications. However, RN 3 did not check the	F 322		

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F 322	Continued From page 12 gastric residual volume prior to the administration of the medications. On November 17, 2011, at 8:25 a.m. during an interview with RN 4, stated she should have checked GT placement and gastric residual volume before she flushed the GT with water and before she administered medication. A review of the literature indicates although there is no consensus on how much is "too much," residual volumes of 200 cc (cubic centimeters) or greater suggest poor tolerance to formula that could lead to regurgitation and aspiration (American Journal of Nursing February 2008, Vol 108, No. 2). Although aspiration occurs without high gastric residual volumes, it occurs significantly more often when volumes are high (American Journal of Critical Care, November 1, 2008, Vol. 17, No. 6 512-519). A review of the facility's policy of the Administering Medication through an Enteral Tube indicated to check placement and gastric contents and to administer medication by gravity flow.	F 322		
F 323 SS=E	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	Tie down straps were purchased and will be applied to all the televisions by the maintenance supervisor. The Administrator will monitor for compliance.	12/22/11

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the residents' environment free of accident hazards by not securing televisions that could cause the potential for accidents in resident's rooms and failed to ensure that the medication cart was always locked if left unattended. Findings: a. On November 10, 2011, from 8:40 a.m. to 9:50 a.m. during a tour of the facility in the presence of Registered Nurse 2, the television (t.v.) sets in Rooms 1, 2, 3, 4, 6, 8, 10, 12, 15, 17, 18, 21, 24 were observed not secured to prevent potential accidents especially in the event of an earth quake. During an interview with Registered Nurse 2 present during the tour, she stated the televisions should have been secured to prevent possible accidents and disasters. Prior to the end of survey on November 18, 2011, all t.v. sets were secured. b. On November 18, 2011, between 8:40 a.m. to 9:30 a.m., during the initial tour of the facility, the television (t.v.) sets were observed not secured in Rooms 25A, 26B, 28A, 29A, 31A, 32B, 33A, 33B, 36B, 37B, 38A, and 39A. The t.v.s were located either on the bedside stand or on top of the closets that were above 6 feet. On November 18, 2011, at 9:50 a.m., during an interview with Registered Nurse 1 (RN 1), she	F 323		

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	055146	A. BUILDING _____ B. WING _____	11/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 14 stated the television sets need to be secured for safety purposes to prevent accidents and injuries. Prior to the end of survey on November 18, 2011, all t.v. sets were secured.	F 323		
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. 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.	F 431	The trash barrels have been removed from the storage room by the maintenance supervisor and will no longer be stored in the room. The Administrator will monitor for compliance. All licensed staff will be in-serviced by the DON concerning Security of Medication Carts. The Administrator, DON, ADON, DSD and RN supervisors will monitor daily for compliance. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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F 431	Continued From page 15	F 431		

This REQUIREMENT is not met as evidenced by:
b. On November 18, 2011, between 8:25 a.m. to 9:30 a.m. during a general tour of the facility with the maintenance supervisor the following was observed in the central supply room:

1. There were approximately 80 boxes (six bottles of 1500 milliliters formula in each) of gastric tube feeding formula stored with two trash barrels.

2. There were six boxes (24 cans of 8 ounce in each box) stored with trash barrels. One of the trash barrel was half filled with trash and the other trash barrel contained black liquid at the bottom. Based on observation and interview, the licensed nurse failed to ensure that unattended medication cart parked in the hallway would not be left unlocked in order to observe safe and secure medication storage in accordance with the State and Federal laws.

Findings:

On November 17, 2011, at 8:50 a.m., during the medication pass observation, Licensed Vocational Nurse 2 (LVN 2) was observed to wash hands before preparing the medication. Then she preceded to pass medication while the medication cart was left parked in the hallway unattended, unlocked and with the keys attached to the opened cart.

On November 17, 2011, at 9:30 a.m., during an interview with LVN 2, she stated she forgot to

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F 431	Continued From page 16 lock the medication cart and should have kept it locked. The facility's policy and procedure titled "Security of Medication Cart" dated April 2007, indicated the medication cart shall be secured during medication passes. Medication carts must be securely locked at all times when out of the nurse's view.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441	The deficient practice was corrected when it was identified. All licensed staff will be in-serviced by the DON concerning proper use of respiratory care equipment to prevent the spread of infection. The DON, ADON, DSD and RN supervisors will monitor daily for compliance. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11

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	055146	A. BUILDING _____ B. WING _____	11/16/2011

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F 441	Continued From page 17 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the respiratory care equipment, such as a humidifier bottle used for a resident with pneumonia was properly labeled with dates changed (4), and failed to ensure that the Hand Held Nebulizer (HHN) was stored properly to prevent the potential for infection (17) for one out of 16 sample residents and one random resident (4, 17). Findings: a. According to the admission record, Resident 4 was readmitted to the facility on November 2, 2011, with diagnoses that included pneumonia and cardiovascular disease. The resident had a physician's order dated November 3, 2011, to administer oxygen at four liters per minutes. On November 16, 2011, at 9:40 a.m., Resident 4 was observed receiving oxygen via nasal canula at four liters per minute and the humidifier bottle was observed connected to the oxygen machine.	F 441		

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F 458	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the administration failed to provide at least 80 square feet per resident in multiple resident bedrooms. Findings: During the survey dates from November 16 - 18, 2011, the following: 1. Rooms 1-8, 10, 12, 14, 15, 16, 17, and 26-31 had two bedrooms 2. Rooms 18-24 had three bedrooms. All of the above rooms occupied by multiple residents did not measure at least 80 square feet per resident. At the time of the observation the patient care was not affected by the room size.	F 458		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide a sanitary environment for the residents and the staff.	F 465		

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F 441	Continued From page 18 There was no date labeled on the humidifier bottle indicating when it was placed or changed. During an interview with RN 2 on November 16, 2011, at 9:45 a.m., at the same time, she was not able to say when the humidifier bottle was changed on the oxygen machine and was not able to provide any documentation indicating when the humidifier bottle had been changed. She stated the humidifier bottle should have been labeled with the date it was replaced. A review of the facility's policy of oxygen therapy indicted to replace the oxygen humidifier every seven days or sooner if the bottle is empty. b. On November 17, 2011, at 12:10 p.m. during medication pass observation Resident 17's the HHN tubing was observed out of the bag and part of the tubing was touching the floor. When asked, Licensed Vocational Nurse 1 (LVN 1), stated the HHN tubing should have been properly stored inside the plastic bag. A review of the facility's policy of the Nebulizer Therapy indicated to place the nebulizer back into the resident's set up bag and leave at the bedside for further treatments. A review of the policy of the Oxygen Therapy indicated to place the oxygen tubing into a set up bag and leave at the bedside when not in use.	F 441		
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.	F 458	The Administrator has applied for a waiver for the identified rooms.	11/6/11

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F 465	Continued From page 20 Findings: On November 18, 2011, between 8:25 a.m. to 9:30 a.m. during a general tour of the facility with the maintenance supervisor, following was observed. 1. There was a sticky brown substance on the shelf where medication bottles were stored in general storage. 2. There was dust accumulated of the ventilator in the laundry room. 3. Three places of wall plaster were peeling off in the laundry room. They were approximately four inches by one inch, five inches by five inches, and two inches by one inch. 4. There was one old closed window approximately one foot by three feet with accumulation of dust and dirt in the laundry room clean area. 5. There were black substances all over the floor grout in the shower room of Nursing Station III and the shower room next to Room 20.	F 465	All the deficient items identified were corrected by the maintenance supervisor. The Administrator will monitor for compliance during daily rounds. The regional supervisor for maintenance, housekeeping and laundry will monitor during his monthly visit and report any deficiencies to the Administrator. Continued issues of non-compliance will be presented to the QA Committee for resolution.	12/22/11