STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555427	A. BUILDING _____ B. WING _____	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ESCONDIDO	1980 FELICITA ROAD ESCONDIDO, CA 92025

(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 California Department of Public Health during an annual re-certification survey, conducted from 6/5/17 through 6/8/17. For purposes of severity and scope determination, the census at the time of the survey was 105 with a sample size of 21. Representing the Department were Health Facilities Evaluator Nurses 38175, 29270, 33280, 38630, 29497, and Health Facilities Evaluator Supervisor 14185. Complaints: CA 00537592, CA 00537757, CA 00538110, CA 00538499, CA 00537580 and CA00538545 were incorporated into the survey. There were no issues identified throughout the course of investigation for these complaints. Glossary: ADON - Assistant Director of Nursing CP - Consulting Pharmacist DON - Director of Nursing MAR - Medication Administration Record mg - milligram MPD - Plant Maintenance Director MS - Maintenance Supervisor Psychosis - a mental disorder, personality is confused and disconnected from reality.	F 000	RECEIVED CA DEPT OF PUBLIC HEALTH JUL 28 2017 LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that	F 309		7/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/28/2017

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.

MWilkerson RN POC accepted 8-7-17

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F 309	Continued From page 1 applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to coordinate a calendar of care for one sampled hospice resident (39). As a result, the facility was unable to determine	F 309	F000 Preparation and execution of this plan of correction does not mean admission or agreement by the provider of the truth of the facts alleged set forth in the Statement	

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F 309	Continued From page 2 when the hospice staff planned to provide care for the resident, and there was a potential that care would be missed by facility staff. Findings: Resident 39 was readmitted to the facility on 10/25/09, with diagnoses to include Multiple Sclerosis per the facility's Face Sheet. LN 13 said on 6/8/17 at 10:15 A.M., Resident 39 was placed on hospice per the family request on 6/2/17. The hospice paperwork in the log book was reviewed with LN 13, for Resident 39. There was an incomplete hospice calendar in the book for Resident 39. The calendar only indicated the hospice staff which had provided services until 6/7/17. LN 13 also said there was no indication when hospice would provide services, and the staff did not know when to expect hospice. On 6/8/17 at 11 A.M., Resident 39 was observed lying in bed with her family members gathered at the beside on vigil. Per the facility policy titled, Terminal Illness, Death, and Dying, dated 6/8/10, "The coordinated care plan must identify each aspect of care the hospice provider of nursing facility is responsible for regarding the resident."	F 309	of Deficiencies. A – On June 9, 2017 the DON placed a call to the contracted hospice provider for resident 39 and the Care Calendar was updated promptly on this day. B – All other hospice residents have the potential to be affected. On July 28, 2017, all residents with hospice services charts were reviewed to ensure that each resident had a current and complete Care Calendar. No other residents out of 8 hospice residents were noted to be affected. C – DON and ADON contacted the facility contracted hospice providers on June 8 and 9, 2017 and discussed the requirement of having current and complete Care Calendars monthly. DON or designee will audit all hospice charts monthly for the presence of complete and current hospice Care Calendars. Non-Compliance will be immediately corrected. DON provided an in-service to licensed nursing associates on June 14, 19, 21, 23 and July 27, 2017 on the requirement of ensuring that the current hospice Care Calendars in the resident chart are being maintained timely by hospice, and purpose of the noted calendars. D – DON will present audit findings,	

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F 309	Continued From page 3	F 309	involving Care Calendars, to monthly QAPI for discussion and review by the QA Committee – This will be ongoing until compliance has been achieved for 3 consecutive months and quarterly thereafter.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a toilet and	F 323	F000 Preparation and execution of this plan of	7/28/17

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F 323	Continued From page 4 toilet grab bars, were properly secured in 1 of 2 shower rooms. As a result, there was potential for resident injury when bathroom fixtures were unsecured. Findings: On 6/8/17 at 8:15 A.M., Shower Room 1 was toured with the MS and PMD. The single toilet in Shower Room 1 was loose, easily moved from its base on the floor, when pressure was applied. The grab bars next to the toilet were also loose, easily moved from the wall, when pressure was applied. MS stated that it was loose, and "needed to have someone to come and fix it". The MS and PMD stated they were unaware of the loose fixtures. The Maintenance log book at the nursing station was reviewed after the Shower Room tour, and there was no entry for the loose toilet or grab bars. According to the facility policy, Preventive Maintenance Program: "Standard: To ensure operational reliability...Maintenance Department will respond to and correct all identified problems... in a timely manner".	F 323	correction does not mean admission or agreement by the provider of the truth of the facts alleged set forth in the Statement of Deficiencies. A – The identified toilet in Shower Room 1 was immediately repaired on June 8, 2017 by the Maintenance Department. The identified grab bars next to the toilet noted to be loose were immediately secured on June 8, 2017 by the Maintenance Department. B – On June 8, 2017, PMD & MS conducted facility rounds to evaluate all facility toilets and found a single toilet and grab bars next to the toilet to be affected. The loose toilet and grab bars were fixed at that time by the Maintenance staff. On July 28, 2017, the MS and designees conducted facility rounds to evaluate all grab bars and toilets and found no loose toilet and 2 other grab bars to be affec9fted. The MS immediately tightened the loose grab bars upon identification. C – On June 13, 14, 19, 21, 23 and July 27, 2017, the Executive Director, DON and ADON conducted in-services with staff on the facility process for reporting damaged, loose, or broken equipment or items utilizing the Maintenance Log Book. The Maintenance Log Book will be reviewed by the MPD or designee each business day at various times. Logs are	

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F 323	Continued From page 5	F 323	located in each nursing station. The Executive Director or designee, will conduct weekly audits of the Maintenance Log Book to ensure issues identified and logged are being addressed timely. The Executive Director or designee, will make weekly rounds to audit 5 randomly selected grab bars and 5 randomly selected toilets to ensure that they are secured. Any deficiencies identified will be immediately corrected and reflected on audits accordingly. D – The Executive Director will present audit findings, to monthly QAPI for discussion and review by the QA Committee – This will be ongoing until compliance has been achieved for 3 consecutive months and quarterly thereafter.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		7/28/17

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F 329	Continued From page 6 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 document the behaviors of a resident on antipsychotic medication, for 1 of 21 sampled residents (63). The facility also failed to coordinate diabetic meals and snacks with insulin administration for 2 randomly sampled residents (93,106). As a result, Resident 63 had the potential of receiving unnecessary medication without behavior monitoring, and Residents 93 and 106 had the potential to have a hypoglycemic reaction	F 329	F000 Preparation and execution of this plan of correction does not mean admission or agreement by the provider of the truth of the facts alleged set forth in the Statement of Deficiencies. A – The DON and ADON conducted in-services on June 14, 19, 21, 23 and July 27, 2017 to educate Licensed Nursing Associates on the facility Policy & Procedure on Medication Administration and importance of accurate completion of	

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F 329	Continued From page 7 (low blood sugar). Findings: 1. Resident 63 was re-admitted to the facility on 3/31/17, with diagnoses which included anxiety disorder, muscle weakness, and psychotic disorder per the facility's Face Sheet. On 6/6/17 at 10:30 A.M., Resident 63 was observed in his room sitting in a wheelchair watching the television with a visitor. At 10:50 A.M., a record review was conducted. Resident 63 was prescribed Seroquel 25 mgs (a medication used to treat hallucination) three times a day. The Behavior/Intervention Monthly Flow Record for the month of April 2017 was missing three days of documentation of staff monitoring the targeted behavior, "striking out towards staff." The Behavior/Intervention Monthly Flow Record for the month of May 2017 was missing two days documentation of staff monitoring for the targeted behavior, "striking out towards staff." On 6/6/17 at 11:10 A.M., an interview was conducted with the DON. The DON reviewed the Behavior/Intervention Monthly Flow Record and confirmed the documentation was incomplete. On 6/6/17 at 4:15 P.M., an interview was conducted with CNA 12 and LN 13. CNA 12 stated Resident 63 had been quiet since she started her shift. CNA 12 further stated Resident 63 had episodes of hitting staff in the past. LN 13 stated Resident 63's behavior varied, had behavioral issues of hitting staff, and currently on	F 329	Behavior/Intervention Monthly Flow Record. Blood Sugar Finger Sticks were immediately performed to rule out low blood sugar and breakfast trays were then promptly provided to the residents. B - All resident with behavior monitoring with associated medications have the potential to be affected. DON and DSD conducted a random audit of 10 residents' behavior summary records which showed 1 gap on the behavior summary sheet on 1 resident. The DON immediately provided an in-service to the LNs on complete, accurate and proper documentation of the behavior summary of residents on July 28, 2017. All resident who receive sliding scale insulin have the potential to be affected. Residents with orders for blood sugar finger sticks and insulin per sliding scale were reviewed with Physician notification and orders clarified based on insulin order to ensure administration was within acceptable time of meal/snack delivery, resident/resident care representative notified accordingly. C – On June 8, 2017, the Pharmacist consultant conducted an in-service with the Licensed Nurses on insulin administration, onset time and storage. On June 14, 19, 21, 23 and July 27, 2017 the DON and ADON conducted	

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F 329	Continued From page 8 an antipsychotic medication. Per facility's undated policy entitled Administration of Medication, "...A physician order that includes... other required considerations including the purpose, diagnosis, or indication for use is required..." The facility did not provide a policy and procedure for documentation on the Behavior/Intervention Monthly Flow Record. 2. Resident 93 was admitted to the facility on 5/29/17, with diagnoses to include diabetes (a blood sugar disorder), per the facility's Face Sheet. On 6/7/17 at 7:05 A.M., LN 1 stated all the insulin for residents had been administered by the night shift. The MAR was jointly reviewed with LN 1 on 6/7/17 at 7:30 A.M., for Resident 93. LN 1 said, the night nurse indicated on the MAR she had tested the blood sugar of Resident 93 at 6 A.M., and recorded the result as 145. Per the physician's order, there was sliding insulin scale (predetermined range of insulin to be administered by fingerstick blood testing) for Resident 93. When the blood sugar range for Resident 93 was between 125 and 149, 2 units of Humalog insulin was to be administered before meals. Per the same MAR, 2 units of Humalog was administered by the night nurse at 6 A.M. LN 1 said insulin should be given close to meal	F 329	in-services with Licensed Nursing Associates on the facility Policy & Procedure on Medication Administration, Guidance on Insulin Use in Diabetes and importance of accurate completion of Behavior/Intervention Monthly Flow Record. Health Information Management department will conduct audits three times weekly for completion of Behavior/Intervention Monthly Flow Records. Audit findings will be provided to involved nurse for timely follow up. Additionally, audit findings will be provided to DON for oversight. The Pharmacy Consultant reviewed all Insulin orders to determine appropriateness of order and time of administration. Pharmacy recommendations were made and promptly followed up by facility accordingly. Pharmacy Consultant will continue to review appropriateness of insulin times of administration in coordination of with meal times each month. The charts of newly admitted residents will be reviewed during Clinical Meetings each week day to ensure appropriateness of orders, to include times of administration including insulin administration to meal deliveries. DON or designee will conduct random audits of 10 residents who receive insulin	

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F 329	Continued From page 9 times, not at 6 A.M. LN 1 also said the breakfast trays, never arrived before 7:30 A.M., which was 1.5 hours after the insulin had been administered. Resident 106 was admitted to the facility on 3/24/08, with diagnoses to include diabetes, per the facility's Face Sheet. The MAR was jointly reviewed with LN 1 on 6/7/17 at 7:35 A.M., for Resident 106. LN 1 said, the night nurse indicated on the MAR she had tested the blood sugar of Resident 106 at 6 A.M., and recorded the result as 239. Per the physician's order, when the blood sugar range for Resident 106 was between 200 and 249, 1 unit of Novolin R (a regular insulin medication) was to be administered before meals. Per the same MAR, 1 unit of Novolin R was administered by the night nurse at 6 A.M. LN 1 said on 6/7/17 at 7:45 A.M., Resident 106's breakfast tray had just been removed from the cart and was taken to the room. The Consultant Pharmacist (CP) was interviewed on 6/7/17 at 2:45 P.M. in the presence of the ADON. The CP said it was preferable for Humalog insulin to be given 15 minutes before or immediately after a meal to prevent hypoglycemia (low blood sugar). The CP also said Regular insulin should be given within 30 minutes of a meal. The CP said the facility did not follow the pharmacy insulin policy. The CP presented the diabetic policy used by the	F 329	once a month to ensure appropriateness of insulin administration time to meal delivery times. D – HIM Director will present audit findings, involving Behavior/Intervention Monthly Flow Record completeness, to monthly QAPI for discussion and review by the QA Committee – This will be ongoing until compliance has been achieved for 3 consecutive months and quarterly thereafter DON will present audit findings, involving Insulin Administration, to monthly QAPI for discussion and review by the QA Committee – This will be ongoing until compliance has been achieved for 3 consecutive months and quarterly thereafter	

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F 329	Continued From page 10 facility. The ADON said the staff had not followed the insulin policy. Per the pharmacy policy used by the facility, Diabetes Clinical Program, dated 2015, ... 6. meal-time Administration a. Regular insulin can be given approximately 30 minutes before a meal. b. Humalog can be given within 15 minutes before or immediately after a meal. c. Novolog can be given immediately before a meal (e.g., start meal within 5-10 minutes after the injection).	F 329		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure a controlled substance sleeping medication was documented for 1 of 21 sampled residents (62). As a result, there was a potential for diversion of the controlled sleeping medication.	F 425	F000 Preparation and execution of this plan of correction does not mean admission or agreement by the provider of the truth of the facts alleged set forth in the Statement of Deficiencies. A – An investigation was conducted by the	7/28/17

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F 425	Continued From page 11 Findings: 1. Resident 62 was re-admitted to the facility on 4/18/17 with diagnoses which included urinary tract infection, diabetes (abnormal blood sugar in the body), blood clot, gastric (stomach) ulcer with bleeding and perforation per facility's Face Sheet. On 6/6/17 at 9:10 A.M., a record review was conducted for Resident 62. Per the physician's order Resident 62 was supposed to receive Ambien 10 mg.(sleeping pill) at night time as needed for insomnia (inability to sleep). The Care plan approach included, monitor episodes of insomnia in nursing notes, observe for side effects, and as needed charting. Resident 62's MAR for the month of May 2017 was reviewed. The MAR did not indicate resident 62 received the medication Ambien 10 mg. on May 1, 2, 3, 4, and 5 (total of 5 days). The facility's Controlled or antibiotic drug record indicated a staff member removed the medication on the 5 days listed for the month of May. On 6/8/17 at 8:10 A.M., an interview was conducted with the ADON. The ADON confirmed there were no staff initials to indicate the Ambien had been administered to Resident 62. The Controlled or antibiotic drug record indicated the medication had been removed from the bubble pack container. On 6/8/17 at 12:30 P.M., an interview was conducted with LN 11. LN 11 confirmed the Controlled or antibiotic record was signed out and there was no initials on the MAR. LN 11 further stated, "If it's not documented, it was not done."	F 425	DON on July 27, 2017 to rule out medication diversion. Resident 62 discharged from the facility on July 25, 2017. B – All residents who have orders for a controlled classification of medication, have the potential to be affected. DON and DSD conducted a random audit of 10 residents on July 28, 2017 on the Narcotic/controlled medication administration wherein the MAR was compared with the Narcotic/controlled medication count sheet. No other issues were identified during the audit. C – On June 14, 19, 21, 23 and July 27 and 28, 2017, the DON conducted an in-service with the licensed nursing associates to review facility Policy & Procedure titled Administration of Medication, with emphasis on signing appropriately on MAR and as warranted, based on usage, on Narcotic Reconciliation Form and Narcotic Theft/Diversion. DON or designee will audit 5 randomly selected residents MAR and Narcotic Reconciliation Form at each nursing station weekly to ensure completeness in documentation and accountability. Any associate noted to be non-compliant will be re-educated on a 1:1 basis. If associate continues to be non-compliant the corrective action process will be initiated up to termination if warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555427	A. BUILDING _____ B. WING _____	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ESCONDIDO	1980 FELICITA ROAD ESCONDIDO, CA 92025

(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 425	Continued From page 12 Per facility's undated policy entitled Administration of Medication, "13. Initial each medication in the correct box on the MAR after the medication is given."	F 425	D - DON will present audit findings, involving MAR to Narcotic Reconciliation Completeness of documentation, to monthly QAPI for discussion and review by the QA Committee – This will be ongoing until compliance has been achieved for 3 consecutive months and quarterly thereafter.	