We received & accepted Virginia O. Ferreira 5/15/13

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

PRINTED: 05/02/2013
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 |
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| | 056083 | A. BUILDING _____ B. WING _____ | 04/13/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WOODS HEALTH SERVICES | 2600 A STREET LA VERNE, CA 91750 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the Department of Public Health during a RECERTIFICATION Survey.<br><br>Representing the Department of Public Health:<br><br>Surveyor ID: 28074<br>Surveyor ID: 17019<br>Surveyor ID: 16279<br><br>Total Resident Population: 69<br>Total Resident Sample: 15<br><br>Highest Scope and Severity: E | F 000 | Disclaimer: The following plan of correction is completed in accordance with state and federals laws. It is not an admission to the alleged findings shown in the statement of deficiencies.<br><br>2013 MAY 15 AM 10:29<br><br>LOS ANGELES COUNTY HEALTH FACILITIES DIVISION | |
| F 250 SS=E | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide dental services for one (Resident 1) of 15 sampled residents. Resident 1's dental hygienist recommendation was not address. This had a potential to result in the resident not attaining or maintaining dental care needs.<br><br>Findings:<br><br>A review of the admission record of Resident 1 indicated the resident | F 250 | F250<br><br>A. Immediate corrective action for residents identified as being affected:<br>Resident # 1 was assessed and her teeth were cleaned by the dental hygienist on 4/4/13. A tracking system is now in place to assure that residents have a dental evaluation once per year.<br>B. Process of identifying other residents with the potential to be affected: A tracking system is now in place to assure that residents have a | 4-14-13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra Tolley — TITLE: Administrator — (X6) DATE: 5-15-13

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 250 | Continued From page 1<br>was readmitted to the facility on September 22, 2006, with diagnoses that included atrial fibrillation (irregular heart beat), Alzheimer's disease (a brain disease that slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks), and hypertension.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated February 11, 2011, indicated the resident was able to complete the brief interview for mental status, usually understood others and usually made herself understood by others, and required extensive with all activities of daily living (transfer, dressing toilet use and hygiene needs) and required limited assistance with eating.<br><br>During a meal observation on April 12, 2013, at 8 a.m., Resident 1 was observed eating her breakfast in bed. Resident 1 was alert and oriented. Further observation, revealed the resident's front teeth were a brownish color. The resident was asked if any of her teeth bothered her when eating, the resident stated, "Yes, at times." The resident added that she was not sure what to do about it.<br><br>During an interview with the Social Service Designee (SSD) on April 12, 2013 at 8:30 a.m., she stated that referrals to the dentist are made annually and as needed. A review of the copy of the dental record provided by the SSD dated March 10, 2011, indicated in the examination recommendation comments: extremely heavy plaque, needs a cleaning.<br><br>However, there was no documented evidence | F 250 | dental assessment once per year.<br>C. Systemic measures to prevent recurrence: Recommendations that are made by the dental hygienist will be followed up on by the Social Services Designee.<br>D. How system changes will be monitored: Dental hygienist recommendations and follow up will be tracked and reported to the Quality Assurance Committee each month for review to insure effectiveness.<br>E. Date deficiency was corrected:<br>4-24-13 | 4-24-13<br>4-14-13<br>4-14-13<br>4-24-13 |

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| F 250 | Continued From page 2<br>that the recommendation was acted upon by the facility staff. On April 12, 2013 at 9 a.m., during an interview, the social service designee (SSD) stated that the dental records revealed no follow up of the dental hygienist recommendations. | F 250 | F315<br>A) Immediate corrective action for residents identified as being affected:<br>The attending physician for resident #3 and resident #10 was immediately informed of the sediment in the catheter tubing on 4-12-13.<br>B) Process of identifying other resident with the potential to be affected:<br>Residents with catheters will be checked each shift for sediment in the catheter tubing.<br>C) Systemic measures to prevent recurrence:<br>Physician orders for residents with catheters will include monitoring for sediment each shift. This documentation will be audited each month.<br>D) How system changes will be monitored:<br>The audit will be presented to the Quality Assurance | 4-14-13<br>4-14-13<br>4-14-13 |
| F 315 SS=E | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility staff failed to monitor and notify the resident's physicians of the presence of sediments in the urine for two of five residents (3 and 10 ) who had indwelling urinary catheters out of a sample of 15 residents. This deficiency had the potential to result in a delay of necessary care and treatment for the residents.<br><br>Findings:<br><br>a. On April 11, 2013, at 6:20 p.m., during the initial tour observation with Licensed Vocational Nurse (LVN) 3, Resident 3 was observed in bed awake alert and oriented. The resident had an | F 315 | | |

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| F 315 | Continued From page 3<br>indwelling urinary catheter draining yellow with small amount of reddish colored sediments (small particles floating in the urine) in the urinary catheter tubing.<br><br>A review of the admission record of Resident 3 indicated the resident as admitted to the facility on February 2, 2013, with diagnoses that included debility, diabetes mellitus (high blood sugar) and status post surgery of the left foot (open reduction internal fixation (surgically repairing a fractured bone that involves either the use of plates and screws or a rod to stabilize the bone). The physician's admission order dated February 20, 2013, indicated an indwelling urinary catheter to continuous drainage bag for difficult mobilization.<br><br>The MDS dated March 4, 2013, indicated the resident was able to complete the brief interview for mental status, able to understand others, able to make self understood, and required extensive assistance from the staff with activities of daily living. According to the MDS, the resident had an indwelling urinary catheter in place.<br><br>A review of a care plan dated February 22, 2013, indicated the resident required the use of indwelling catheter related to post (after) surgery management of fracture of left ankle with multiple pins. The care plan goal indicated the resident will not manifest signs and symptoms of urinary tract infection and will be provided with adequate catheter care daily. The nursing interventions included to observe and monitor urine output as to color, clarity, amount, presence of sediments. The intervention also stated to refer to the physician the observation. | F 315 | committee each month for review to insure effectiveness.<br>E) Date deficiency was corrected: 4-14-13 | 4-14-13<br>4-14-13 |

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| F 315 | Continued From page 4<br>During an observation on April 12, 2013, at 8 a.m., the resident was observed in bed with an indwelling urinary catheter draining cloudy with red steaks of thick sediments in the urinary catheter tubing.<br><br>On April 12, 2013, at 11 a.m., a review of the nurse's notes revealed no documented evidence that the resident was monitored for the presence of sediments in the indwelling urinary catheter and no documented evidence that the resident's physician was notified.<br><br>During an interview with LVN 3 on the same day at 11:20 a.m., she reviewed the clinical record and was unable to find documentation that the resident was monitored for presence of sediments in the urinary catheter. She stated that there was an order to change the indwelling catheter if plugged. She further stated that she would change indwelling catheter as soon as possible.<br><br>The facility's undated policy and procedure titled "Urinary Drainage," indicated to chart intake and output and color of urine, amount, sediments and notify the physician of all pertinent observations.<br><br>b. During the initial tour observation with licensed vocational nurse (LVN) 3 on April 11, 2013, at 6:45 p.m., Resident 10 was observed in bed with an indwelling urinary catheter. According to LVN 3, the resident had suprapubic catheter (catheter (tube) that drains urine from the bladder. It is inserted into the bladder through a small hole in the belly). Further observation revealed the urinary drainage tubing of the indwelling catheter was observed with scattered, | F 315 | | |

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| F 315 | Continued From page 5<br>yellowish sediment<br><br>A review of the admission record of Resident 10, indicated that the resident was re-admitted to the facility on January 18, 2013, with diagnoses that included chronic kidney disease, debility (loss of strength) and difficulty in walking.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated January 31, 2013, indicated that the resident was able to complete the brief interview for mental status, usually understood others, usually able to make herself understood, and required extensive to total assistance from the staff for most activities of daily living. The MDS further indicated that the resident had an indwelling catheter within the last 14 days.<br><br>A review of the physician ' s admission order dated January 24, 2013, indicated to change suprapubic catheter monthly and as needed (prn) for occlusion (blocked) or dislodged.<br><br>A care plan dated January 17, 2013 indicated the resident required the use of indwelling catheter related to urostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall through which urine leaves the body.) The care plan goal indicated the resident will be provided with adequate catheter care for ninety days and will not manifest signs and symptoms of urinary tract infection. The nursing interventions included to observe and monitor urine output as to color, clarity, amount, presence of sediments. The intervention also stated to refer to the physician the observation. | F 315 | | |

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| F 315 | Continued From page 6<br>On April 12, 2013, at 11:25 a.m., an interview was conducted with LVN 3, who stated all staff should monitor the drainage for any sediments. A review of the nurse's notes revealed no documented evidence that the resident was monitored for the presence of sediments in the indwelling urinary catheter and no documented evidence that the resident's physician was notified. | F 315 | | |
| F 322 SS=D | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that --<br><br>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and<br><br>(2) 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility's staff failed to ensure that two of two residents with G-tubes out of 15 sample | F 322 | F322<br>Resident 5<br>A) Immediate corrective action for residents identified as being affected:<br>The licensed nurse was instructed to check for placement of the gastric tube and check the residual volume of the fluids in the resident's stomach prior to flushing the gastric tube.<br>B) Process of identifying other resident with the potential to be affected:<br>Licensed nurses received instruction on 4-16-13 and 4-29-13 to check for placement of the gastric tube and check the residual volume of the fluids in the resident's stomach prior to flushing the gastric tube. | 4-15-13<br><br>4-29-13 |

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| F 322 | Continued From page 7<br>residents, were provided care and services to prevent complications (5, 4).<br>(Resident 5) The licensed nurse flushed the G-tube with 150 milliliters of water without checking for: 1) placement of the G-tube, and 2) the residual volume of fluids in the resident's stomach.<br>(Resident 4) The licensed nurse mixed medications with applesauce and administered the medications by gastrostomy tube. (GT- a surgically inserted tube in the stomach for the purpose of nutrition and medication) were not mixed This had the potential to result in complications such as gastrostomy tube blockage, or gastrostomy tube dislodgement.<br><br>Findings:<br><br>a. Resident 5 was admitted to the facility on January 30, 2013, with diagnoses that included dementia, dysphagia, and diabetes mellitus. The resident was fed and medicated through a G-tube (a tube inserted through the abdomen into the stomach used for feeding and/or medication administration). The Minimum Data Set (MDS - a standardized assessment and care planning tool) dated March 27, 2013, indicated the resident required assistance with daily activities such as transfers, personal hygiene and bathing.<br><br>On April 12, 2013 at 6:29 a.m., a licensed nurse (LVN 1) was observed as he flushed the resident's G-tube with 150 milliliters of water. LVN 1 did not check for the placement of the G-tube or the amount of residual volume of fluids in the resident's stomach prior to administering the 150 milliliters of water. | F 322 | C) Systemic measures to prevent recurrence:<br>Medication administration via the gastric tube will randomly observed by the nurse supervisor to insure that nurses check for placement of the gastric tube and check the residual volume of the fluids in the resident's stomach prior to flushing the gastric tube.<br>D) How system changes will be monitored: Medication administration will be randomly monitored by the nurse supervisor to insure that nurses check for placement of the gastric tube and check the residual volume of the fluids in the resident's stomach prior to flushing the gastric tube. This monitor will be documented and presented to the Quality Assurance Committee on a monthly basis. | 4-29-13<br>4-29-13 |

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| F 322 | Continued From page 8<br><br>During an interview on April 12, 2013 at 6:46 a.m., LVN 1 stated that he forgot to check the placement of the G-tube and the residual volume prior to administering the flush. A care plan dated February 5, 2011, indicated to check tube placement and patency every shift, and to check and record residuals every shift and to notify the physician for residual volume greater than 100 milliliters.<br><br>The facility's undated policy and procedures titled "Medication Administered through an Enteral Tube", indicated to check for placement prior to administration of medications.<br>b. On April 12, 2013 at 6:30 a.m., LVN 4 was observed as she administered Resident 4's morning medications via G-tube.<br><br>During the observation, LVN 4 stated that she had already prepared the medication, Synthroid (a replacement for a hormone that is normally produced by the thyroid gland to regulate the body's energy and metabolism) 100 micro-milligrams (mcg). LVN 4 stated to the surveyor that she crushed the tablet of Synthroid and added a small amount of applesauce to make it easier for the medication to pass through the GT. LVN 4 then poured between 20 and 30 milliliter (ml) of water into the medication cup. LVN 4 then administered all the medication with applesauce into the GT. She then administered 30- 40 ml of water to the GT after the administration of the medication. During an interview after the medication administration, LVN 4 stated that she normally administers all the medications with applesauce. | F 322 | E) Date deficiency was corrected: 4-29-13<br><br>Resident 4<br>A) Immediate corrective action for residents identified as being affected:<br>The licensed nurse was instructed not to use applesauce when administering medications via the gastric tube. Licensed nurses received instruction on 4-16-13 and 4-29-13 to mix medications with water only when administering via the gastric tube.<br>B) Process of identifying other resident with the potential to be affected:<br>Licensed nurses received instruction on 4-16-13 and 4-29-13 to mix medications with water only when administering via the gastric tube. | 4-29-13 |

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| F 322 | Continued From page 9<br>A review of the admission record indicated that Resident 4 was admitted to the facility on August 3, 2012, with diagnoses that included aphasia (difficulty in talking), dysphagia (difficulty in swallowing), diabetes mellitus and gastrostomy tube.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated February 19, 2013, indicated the resident had modified independence in cognitive (mental) skills for daily decision-making, usually understood others, rarely made self understood and required extensive assist in performing activities of daily living.<br><br>A review of the physician's order with LVN 4 indicated that there was no physician's order to mix the resident's medications with applesauce prior to administering through the GT. During the interview, LVN 4 stated that it was just her own way of administering medications via GT. LVN 4 further stated that so far there had been no problems such as blockage and tube dislodgement.<br><br>During an interview with the director of nurses (DON) on April 12, 2013 at 11:30 a.m., she stated that it was never a practice to mix medications with applesauce before administering through the GT.<br><br>The facility's undated policy and procedures for medication administration did not indicate to add applesauce to medications prior to administering via G tube. | F 322 | C) Systemic measures to prevent recurrence: Medication administration via the gastric tube will randomly observed by the nurse supervisor to insure that the medications administered via the gastric tube are mixed with water only.<br>D) How system changes will be monitored: Medication administration will be randomly monitored by the nurse supervisor to insure that the medications administered via the gastric tube are mixed with water only. This monitor will be documented and presented to the Quality Assurance Committee on a monthly basis.<br>E) Date deficiency was corrected:<br>4-29-13. | 4-29-13<br>4-29-13<br>4-29-13 |
| F 328 SS=E | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS | F 328 | | |

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| F 328 | Continued From page 10<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility staff failed to follow the physician's order for oxygen (O2) therapy for two residents (2 and 10) who used oxygen therapy in a total sample of 15.<br><br>Resident 2 was observed receiving O2 at a rate of 2 liters per minute (lpm) via nasal cannula (a thin tube with two small nozzles that protrude into the patient's nostril) but the O2 tubing was not connected to the O2 concentrator (a portable source of oxygen).<br>Resident 10 was observed receiving O2 at a rate of 3.25 lpm via nasal cannula, the physician had ordered oxygen at 2 liters per minute as needed.<br><br>This had the potential to result in complications from receiving more or less oxygen than the body requires.<br><br>Findings: | F 328 | F328<br><br>Resident 2<br>A) Immediate corrective action for residents identified as being affected:<br>O2 tubing was immediately connected to the concentrator.<br>B) Process of identifying other resident with the potential to be affected:<br>All oxygen tanks and concentrators were checked to verify that the tubing was properly connected.<br>C) Systemic measures to prevent recurrence:<br>Oxygen tubing will be checked during shift rounds to verify that it is properly connected.<br>D) How system changes will be monitored:<br>This check will be documented and presented to the quality assurance committee each month to | 4-14-13<br>4-14-13<br>4-24-13 |

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| F 328 | Continued From page 11<br><br>a. During the initial tour observation with licensed vocational nurse (LVN) 3 on April 11, 2013 at 6:20 p.m., Resident 2 was observed in sitting in her wheelchair in her room. The resident was observed with a nasal cannula on her nostrils. Further observation revealed that the O2 tubing was not connected to the O2 concentrator. During the interview at the same time, Resident 2 stated that she had been on O2 inhalation continuously for some time. LVN 3 then stated that the resident was on continuous O2 inhalation set at 2 lpm due to her diagnosis of COPD and CHF. Then LVN 3 then walked towards the door without inspecting whether the O2 tubing was connected to the source of oxygen. LVN 3 was asked if she had noticed anything wrong with Resident 3's O2 tubing. LVN 3 stated, "no."<br><br>A review of the admission record indicated that Resident 2 was re-admitted to the facility on January 13, 2013, with diagnoses that included hypertension, chronic obstructive pulmonary disease (COPD- one of the most common lung diseases. that makes it difficult to breathe) and congestive heart disease (CHF- is a condition in which the heart's function as a pump is inadequate to meet the body's needs) and diabetes mellitus (high blood sugar).<br><br>A review of a physician's order dated February 18, 2013, indicated to administer O2 inhalation at a rate of two L/min via nasal cannula continuously for COPD and to check O2 liter flow to ensure proper flow. | F 328 | insure that the process is effective.<br>E) Date deficiency was corrected:<br>4-29-13<br><br>Resident 10<br>A) Immediate corrective action for residents identified as being affected:<br>The oxygen setting was immediately placed at the setting the physician ordered.<br>B) Process of identifying other resident with the potential to be affected:<br>All oxygen tanks and concentrators were checked to verify that the settings were as the physician ordered.<br>C) Systemic measures to prevent recurrence:<br>Oxygen settings will be checked each shift to insure that the oxygen is being | 4-29-13<br>4-29-13<br>4-14-13<br>4-14-13 |

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| F 328 | Continued From page 12<br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated February 12, 2013, indicated that the resident was able to complete the brief interview for mental status, had the ability to make self understood by others, had the ability to understand others and required extensive assistance with bed mobility and transfer, ambulation, dressing, personal hygiene, and toilet use. The MDS further indicated that the resident received oxygen therapy within the last 14 days.<br><br>A care plan dated January 21, 2013, indicated that the resident had impaired respiratory function related to COPD and CHF. The care plan goal indicated that the resident will show no signs of respiratory distress every day and will tolerate activities without any signs and symptoms of shortness of breath (SOB), weakness and easy fatigue. The listed nursing interventions included to provide oxygen at 2 lpm via nasal cannula as ordered.<br><br>Before proceeding with the initial tour with LVN 3, the surveyor informed the LVN that the O2 tubing was not connected to the O2 concentrator, thus not providing O2 to the resident. LVN 3 then went back to the room and inspected the O2 tubings. LVN 3 then confirmed to the surveyor that the tubings were not connected. LVN 3 then assessed the resident, checked the oxygen saturation (refers to the amount of oxygen that is carried through the blood by the red blood cells, as well as what is dissolved in the body tissues), which was 93 % (healthy blood oxygen saturation is between 95 and 100 percent, but patients with lung disease such as COPD, often have a lower percentage unless they use supplementary | F 328 | administered per the physician order.<br>D) How system changes will be monitored:<br>Oxygen settings will be monitored each shift and documented on the treatment administration record to insure that the oxygen is being administered per the physician order. This check will be audited and presented to the quality assurance committee each month to insure that the process is effective.<br>E) Date deficiency was corrected:<br>4-29-13 | 4-29-13<br>4-29-13<br>4-29-13 |

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oxygen). LVN 3 then stated that she should have checked the O2 set up before leaving the room.

b. During the initial tour observation with licensed vocational nurse (LVN) 3 on April 11, 2013 at 6:45 p.m., Resident 10 was observed in bed asleep. The resident was observed receiving oxygen inhalation at a rate of three and quarter liters per minute (L/min) continuously via nasal cannula. LVN 3 read the oxygen flow rate aloud, and stated the oxygen was flowing at a rate of three and a quarter liters per minute via nasal cannula.

A review of the admission record indicated that Resident 10 was re-admitted to the facility on January 18, 2013, with diagnoses that included chronic kidney disease, debility (loss of strength) and difficulty in walking.

The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated January 31, 2013, indicated that the resident was able to complete the brief interview for mental status, usually understood others, usually able to make herself understood, and required extensive to total assistance from the staff for most activities of daily living. The MDS further indicated that the resident received oxygen therapy within the last 14 days.

A review of a physician's order dated January 20, 2013, indicated to administer oxygen inhalation at a rate of two L/min by nasal cannula as needed for shortness of breath (SOB) or to keep the

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| F 328 | Continued From page 14<br>oxygen saturation greater than 92 percent (%).<br><br>A care plan dated January 20, 2013, indicated that the resident had impaired respiratory function related to a diagnosis of congestive heart failure (CHF). The care plan goal indicated that the resident will show no signs of respiratory distress daily. The listed nursing interventions included to provide oxygen as ordered at 2 lpm via nasal cannula as needed for SOB or to keep O2 saturation above 92%.<br><br>During an interview with LVN 3, she stated that the resident was only supposed to be receiving two L/min of oxygen and not three and a quarter L/min according to the physician's order. LVN 3 also stated that nursing staff document every time the resident was administered the O2. LVN 3 was then observed adjusting the oxygen concentrator and lowering the oxygen rate to two L/min.<br><br>The facility's undated policy and procedure titled "Oxygen and Humidifier," indicated that oxygen therapy is administered as ordered by the physician. | F 328 | F329<br>A) <u>Immediate corrective action for residents identified as being affected:</u><br>The attending physician(s) were contacted and permission to perform gradual dose reductions were received as follows:<br><u>Resident #1</u>, Celexa was reduced to 20mg every day on 4/23/13<br><u>Resident #8</u>, Celexa was reduced to 10 mg every day on 4/23/13<br><u>Resident #11</u> , Ambien was reduced to 2.5 mg every night on 5/7/13, and Celexa was reduced to 20mg every day on 4/15/13<br><u>Resident #13</u> , Depakote was reduced one time per day, at bed time on 4/22/13, and Zyprexa was reduced to 2.5mg every other day on 5/2/13 | 4-23-13<br>4-23-13<br>5-7-13<br>5-2-13 |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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. | F 329 | | |

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| F 329 | Continued From page 15<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that gradual dose reductions were attempted for 4 of 5 sampled residents (1, 8, 11 and 13) who used psychotropic drugs in a total sample of 15 residents. This had a potential to result in failing to identify the need for drug reductions that are necessary and can result in adverse consequences associated with medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status.<br><br>Findings:<br><br>a. A review of the admission record indicated Resident 1 was readmitted to the facility on | F 329 | B) Process of identifying other resident with the potential to be affected: The record of each resident receiving antipsychotic medication will be reviewed to insure that a gradual dose reduction will be attempted as per the regulatory requirements.<br>C) Systemic measures to prevent recurrence:<br>The consultant pharmacist will review antipsychotic medication for each resident and make recommendations to each attending physician to attempt a gradual dose reduction as per the regulatory requirements. The Director of Nursing services will monitor the recommendations to insure that permission is received from the attending physician to attempt the gradual dose reduction as per the regulatory requirements. | 5-15-13 |

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| F 329 | Continued From page 16<br>September 22, 2006, with diagnoses that included atrial fibrillation (irregular heart beat), Alzheimer's disease (a brain disease that slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks), and hypertension.<br><br>A physician's order dated January 5, 2010, indicated to administer Remeron 15 milligrams (mg) every night at bedtime for depression manifested by poor appetite and Celexa 30 mg every day for depression manifested by lack of interest in being cared for.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated February 11, 2011 indicated the resident was able to complete the brief interview for mental status, usually understood others and usually made herself understood by others, and required extensive with all activities of daily living (transfer, dressing toilet use and hygiene needs) and required limited assistance with eating.<br><br>A review of the behavior monitoring for depression manifested by resistive to care, yelling out and cursing revealed the resident had zero (0) episodes of behavior from April 1 to April 12, 2013, zero episodes for the months of February 2013 and March 2013.<br><br>A review of the Pharmacist's Consultation Report dated May 26, 2012, through June 29, 2012, and August 1, 2012, through August 29, 2012, indicated to consider a gradual dose reduction for the Celexa and Remeron. The pharmacist recommended to reduce the dose of Celexa to 20 mg every day. However, there was no evidence | F 329 | D) How system changes will be monitored:<br>This monitor will be documented and presented to the quality assurance committee each month to verify that the process if effective.<br><br>E) Date deficiency was corrected:<br>5-15-13. | 5-15-13<br><br>5-15-13 |

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| F 329 | Continued From page 17<br>that a dosage drug reduction was attempted and no evidence that a gradual dose reduction was clinically contraindicated.<br><br>During an interview with Resident 1 on April 13, 2013 at 8:30 a.m., she stated that she was very happy with the care of the staff in the facility. Resident 1 further stated that she was just not a "big eater." At the same time, in an interview with the certified nurse aide, she stated that Resident 1 had always been cooperative and always aware of what she needs. Throughout the survey from April 11, 2013, to April 13, 2013, the resident was observed either up in the wheelchair or resting in bed. Resident 1 was not observed manifesting signs of being resistive to care nor having episodes of yelling.<br><br>During an interview with the Director of Nursing (DON) on April 13, 2013, at 1 p.m., she stated that the resident's physician refused to reduce the dosage of Celexa and Remeron. The DON also reviewed the clinical record and was unable to find documented evidence that a drug dosage reduction was clinically contraindicated.<br><br>b. A review of the admission record indicated Resident 11 was admitted to the facility on June 3, 2011, with diagnoses that included depressive behavior, dysphagia (difficulty in swallowing), hypertension (high blood pressure) and anxiety.<br><br>A physician's order dated February 2, 2012, indicated to administer Xanax 0.25 mg every 6 hours as needed for anxiety manifested by verbalizing nervousness per resident's request. | F 329 | | |

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| F 329 | Continued From page 18<br>There was another physician's order dated February 28, 2012, that indicated to administer Celexa 30 mg every day for depression manifested withdrawal from activities. On March 27, 2012, the physician ordered to administer Ambien 5 mg every night for insomnia.<br><br>The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated March 15, 2013, indicated the resident was able to complete the brief interview for mental status, had the ability to make self understood by others, had the ability to understand others and required extensive assistance with bed mobility and transfer, ambulation, dressing, personal hygiene, and toilet use. According to the MDS, the resident received an antipsychotic medication in the last seven days.<br><br>A review of the behavior monitoring for anxiety and depression revealed the resident had zero episodes of behavior from April 1 to April 13, 2013. A review of several pharmacy Consultation Reports dated November 29, 2011 through December 21, 2011, May 26, 2012 through June 29, 2012, August 1, 2012 through August 29, 2012, September 28, 2012 through October 30, 2012 and January 24, 2013 through February 28, 2013, revealed pharmacist recommendations to attempt a gradual dose reduction for Ambien to 2.5 mg, Xanax to 0.125 mg, and Celexa to 20 mg everyday. However, further review of the clinical records revealed that the physician declined all the recommendations to perform gradual dose reduction or indicated that the gradual dose reduction was clinically contraindicated. However, there was no documented evidence of a rational as to why a gradual dose reduction was | F 329 | | |

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| F 329 | Continued From page 19<br>contraindicated.<br><br>During an observation on April 13, 2013 at 8:30 a.m., the resident was observed in his room awake and lying in his bed. The resident was pleasant and denied that he was depressed and stated he could sleep for 6 hours at night.<br><br>During an interview with the director of nurses (DON) on April 13, 2013 at 1:30 p.m., she stated that there were no gradual dose reductions attempted.<br><br>According to the facility's policy and procedure titled, "Psychopharmacological Medication Use", revised on November 31, 2011, "If the physician/prescriber orders a psychopharmacological medication in the absence of a diagnosis or specific behavior listed in the State Operations Manual, facility should ensure that the ordering physician/prescriber reviews the medication plan and considers a gradual dose reduction (GDR) of psychopharmacological medications for the purpose of finding the lowest effective dose unless a GDR is clinically contraindicated."<br><br>c. According to the admission information, Resident 8 was admitted to the facility on January 20, 2010, with diagnoses that included diabetes mellitus, hypertension and osteoporosis. The Minimum Data Set (a standardized assessment and care planning tool) dated January 19, 2013, indicated the resident was able to make her needs known, but required assistance with daily activities such as transfers, dressing and personal hygiene.<br>The resident has been taking an antidepressant | F 329 | | |

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| F 329 | Continued From page 20<br>medication Celexa 20 milligrams (mg) daily since June 21, 2011, with no dosage reduction. The physician's order dated June 21, 2011, indicated that Celexa was for depression as manifested by withdrawal from activities. However, a review of the Monthly Psychotropic Behavior Summary from January 2012 to March 2013, revealed that the resident had no episode of withdrawal from activities.<br><br>During an interview on April 13, 2013, at 7:30 a.m., the licensed nurse (LVN 2) stated that the resident had been attending activities and did not appear to be depressed. LVN 2 concurred that the resident could be a good candidate for a gradual dosage reduction. The activities notes for the year 2013, also indicated that the resident has been attending activities in and outside of the facility.<br><br>A consultant pharmacist's note to the physician dated June 29, 2012, indicated a recommendation to consider a gradual dose reduction, "perhaps decreasing to Celexa 15 mg qd (daily), while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." The physician declined the pharmacist's recommendation and did not specify specific rationale why a gradual dosage reduction was contraindicated.<br><br>d. According to the admission information, Resident 13 was admitted to the facility on August 9, 2011, with diagnoses that included dementia, diabetes mellitus and hypertension. The MDS | F 329 | | |

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assessment dated 2/16/13 indicated the resident was cognitively impaired and was dependent on staff with daily activities such as transfers and personal hygiene.

The resident has been taking Depakote 125 mg twice daily since October 19, 2011, and Zyprexa 2.5 mg daily since August 29, 2011, without gradual dosage reductions. Both were indicated for psychosis as manifested by "yelling and getting agitated easily." However, a review of the Monthly Psychotropic Behavior Summary from November 1, 2011 to March 1, 2013, revealed that the resident has not exhibited these behaviors.

During an interview on April 13, 2013 at 7:30 a.m., the licensed nurse (LVN 2) stated that the resident has not exhibited these behaviors and stated that the resident could be a good candidate for gradual dosage reduction.

A consultant pharmacist's Consultation Report dated February 28, 2013, revealed a recommendation to the physician that stated "Please consider a gradual dose reduction, perhaps decreasing to Depakote Sprinkles 125 mg qod (every other day) and 125 mg qhs (every bedtime), and Zyprexa 2.5 mg qhs, except Sunday, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." However, a written note at the bottom of this Consultation Report indicated "Resident is doing well on these meds - IDT (interdisciplinary team) recommend no change." There was also a written note which

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| F 329 | Continued From page 22<br>indicated that a nurse practitioner declined a drug reduction.<br><br>During an interview on April 13, 2013 at 9:35 a.m., the Director of Nursing (DON) concurred that the resident was a good candidate for gradual dosage reduction and that the facility will make another recommendation to the physician for gradual dosage reduction. The DON also concurred that these two medications were considered duplicate therapy for the same behaviors (yelling and getting agitated easily).<br>During a follow-up interview on April 13, 2013 at 2:45 p.m., the DON stated that the facility did not have a policy and procedures for gradual dosage reduction of psychotropic medications. | F 329 | F371<br>A) Immediate corrective action for residents identified as being affected:<br>The frozen food was immediately removed from the freezer and placed in another freezer that met the temperature requirements. The freezer was repaired on 4-15-13. | 4-15-13 |
| F 371<br>SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to store and protect food under sanitary conditions, regarding one of four refrigeration units. Freezer #1 was not functioning properly. | F 371 | B) Process of identifying other resident with the potential to be affected: All freezers were checked to insure that the temperature requirements were met.<br>C) Systemic measures to prevent recurrence:<br>Dietary staff were instructed to immediately report temperatures that are not within the required range and remove the food if necessary. The Director of Dining Services/Dietician will check the temperature logs | 4-14-13 |

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

PRINTED: 05/02/2013
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 |
|---|---|---|---|
| | 056083 | A. BUILDING _____ B. WING _____ | 04/13/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WOODS HEALTH SERVICES | 2600 A STREET LA VERNE, CA 91750 |

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| F 371 | Continued From page 23<br>Findings:<br><br>On April 11, 2013 at 6:15 p.m., during the initial kitchen observation, of four refrigeration units throughout the kitchen revealed that refrigerator #2, freezer #3 and the walk-in refrigerator were at the proper temperatures. But freezer #1's exterior digital thermometer showed the freezer's internal temperature was 21 degrees Fahrenheit (F). This freezer contained frozen meats and vegetables.<br><br>At 6:20 p.m., the evaluator reviewed freezer #1's April 2013, refrigerator/freezer temperature log. The log showed that between April 1 and April 11, 2013, freezer #1's temperatures were recorded between 8 degrees F and 15 degrees F. (The log indicated that the acceptable freezer temperatures should be between -10 F and 0 F.)<br><br>On April 12, 2013 at 7:30 a.m., the evaluator observed that an "out of order" sign was posted on freezer #1 and all the food items were removed.<br><br>On April 12, 2013 at 8:45 a.m., the evaluator conducted an interview with the dietary supervisor regarding freezer #1's internal temperature. The dietary supervisor stated that the freezer had not been cooling properly and the refrigeration serviceman was called out to look at it.<br><br>On April 13, 2013 at 6:55 a.m., during the kitchen observation, freezer #1's internal temperature was -2 F.<br><br>On April 13, 2013 at 8:33 a.m., the evaluator conducted an interview with the dietary supervisor regarding freezer #1. The dietary supervisor | F 371 | and indicate her review on a weekly basis.<br>D) How system changes will be monitored:<br>The Director of Dining Services/Dietician will check the temperature logs and indicate her review on a weekly basis. This review will be documented and presented to the quality assurance committee each month to insure the effectiveness of the process.<br>E) Date deficiency was corrected:<br>4-22-13. | 4-22-13<br>4-22-13<br>4-22-13 |

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| F 371 | Continued From page 24<br>stated that the refrigeration serviceman repaired it on April 12, 2013. | F 371 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of | F 441 | | |

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| F 441 | Continued From page 25<br>infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility's staff failed to maintain an Infection Control Program to help prevent the development and transmission of disease and infection for two (Resident 5 and 10) of 15 sample residents and two randomly-selected residents (RSR 16 and RSR 17).<br><br>The licensed nurse failed to wash his hands after handling Resident 5's gastrostomy tube (G-tube). This had a potential to result in the spread of infections and cross-contamination within the facility.<br><br>The licensed nurse failed to wash his hands after checking the blood sugar of and injecting insulin to RSR 16 and RSR 17. This had the potential to result in the the spread of blood borne infections.<br><br>For Resident 10, the O2 tubings were observed uncovered, exposed and coiled around the O2 tank. This had the potential to result in oral and respiratory infection from the use of a soiled nasal cannula.<br><br>There was no documented evidence that one newly-hired licensed nurse's tuberculosis skin test was read/reassessed so as to complete for TB screening. This had the potential to result in the spread of infections in the facility.<br><br>Findings: | F 441 | F441<br>Hand washing<br>A) Immediate corrective action for residents identified as being affected:<br>Licensed nurses were instructed to wash their hand during medication administration, before and after giving medication.<br>B) Process of identifying other resident with the potential to be affected: Licensed nurses were instructed to wash their hand during medication administration, before and after giving medication.<br>C) Systemic measures to prevent recurrence:<br>Medication administration, including proper hand washing, will be randomly monitored by supervisors.<br>D) How system changes will be monitored: This monitor will be documented and presented to the quality assurance committee for | 4-30-13<br>4-30-13<br>4-30-13 |

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| F 441 | Continued From page 26<br><br>a. On April 11, 2013 at 6:17 a.m., a licensed nurse (LVN 1) was observed as he checked the blood-sugar of and injected insulin to RSR 16. After these procedures, LVN 1 removed his gloves and proceeded to attend to Resident 5. LVN 1 handled Resident 5's G-tube (a tube inserted through the abdomen into the stomach used for feeding and/or medication administration) and flushed it with 150 milliliters of water. After the procedure, LVN 1 removed the gloves and proceeded to RSR 17 for whom he checked the blood-sugar and injected insulin. After removing the gloves, LVN 1 started to prepare medications for another resident. The surveyor then asked LVN 1 what he failed to do. LVN 1 stated that he forgot to wash his hands after each of the above procedures and before seeing the next resident.<br>The facility's undated policy and procedures, titled "Handwashing," indicated "The single most effective thing you can do to prevent the spread of disease is to correctly wash your hands." The policy and procedures indicated that hand washing should be done "After you handle items or care of residents with body fluids or wastes (blood, vomit, stool, urine, drool, eye matter)."<br><br>b. During the initial tour on April 11, 2013 at 6:30 p.m., in the presence of the licensed vocational nurse ( LVN) 3, Resident 10 was observed lying in her bed. Further observation revealed a wheelchair located near the resident's clothes closet. At the back of the wheelchair was a portable oxygen (O2) tank attached to the back of the wheelchair. During this observation, the oxygen tubing was observed uncovered, wrapped around the portable oxygen tank and exposed. | F 441 | review to insure effectiveness.<br>E) Date deficiency was corrected:<br>4-~~30~~-13.<br><br>Oxygen tubing<br>A) Immediate corrective action for residents identified as being affected: The tubing was immediately unwrapped and properly placed.<br>B) Process of identifying other resident with the potential to be affected: All residents with oxygen were checked to insure that the tubing was not wrapped and that the tubing was properly placed. Nursing staff received instruction to monitor oxygen tubing for proper placement.<br>C) Systemic measures to prevent recurrence: Oxygen administration and proper placement of oxygen tubing will be checked daily | 4-30-13<br>4-30-13<br>4-14-13<br>4-14-13 |

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| F 441 | Continued From page 27<br>This was observed again on the April 12, 2013 at 11 a.m. with LVN 4 during a general observation.<br><br>During an interview at the same time, LVN 4 stated that Resident 10 would occasionally use the wheelchair with the portable O2. LVN 4 also stated that the O2 tubing should not have been left uncovered and wrapped around the O2 tank.<br><br>According to the facility's undated policy and procedure for, Oxygen and Humidifier, "oxygen tubing not in used must be kept in clean plastic bag."<br><br>c. On April 12, 2013 at 10:45 a.m., a review of six new employee files were conducted. The six employees were hired between August 13, 2012, and December 3, 2012. One of the six employees (a licensed vocational nurse) was hired, on November 15, 2012. The licensed vocational nurse's employee file had a sheet for a tuberculosis (TB) skin test. This licensed vocational nurse's TB skin test was performed, on November 6, 2012, but there was no documentation of the TB skin test results.<br><br>On April 13, 2013 at 10:25 a.m., a review of the facility's policy and procedure for TB testing indicated that all employees shall receive a TB test in accordance with Title 22, section 72535(b), which indicates, "The initial health examination and subsequent annual examination shall include a purified protein derivative intermediate strength intradermal skin test for tuberculosis. A chest x-ray is indicated if the employee has previously had a positive reaction to a tuberculosis skin test or is currently being treated for tuberculosis." | F 441 | during rounds and monitored by the nursing supervisor.<br>D) How system changes will be monitored: This monitor will be documented and presented to the quality assurance committee for review to insure effectiveness.<br>E) Date deficiency was corrected: 4-30-13.<br><br>TB Screening<br>A) Immediate corrective action for residents identified as being affected: The employee was contacted and another TB screen test was performed. The results were negative, which is documented and in the employee file.<br>B) Process of identifying other resident with the potential to be affected: Employees files | 4-30-13<br>4-30-13<br>4-30-13<br>4-19-13 |

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| F 441 | Continued From page 28<br>On April 13, 2013 at 11:30 a.m., the evaluator conducted an interview with the staff developer regarding the licensed vocational nurse's TB skin test results. The staff developer stated that she performed the TB skin test, but did not write down the results. The staff developer mentioned that the licensed vocational nurse's TB skin test was negative. | F 441 | were reviewed to insure that all TB screenings had been properly documented and in the employee files.<br>C) Systemic measures to prevent recurrence: New hire records will be reviewed for completion prior to the employee working with residents.<br>D) How system changes will be monitored: This review will be documented and presented to the quality assurance committee for review to insure effectiveness.<br>E) Date deficiency was corrected:<br>5-14-13 | 5-14-13<br>5-14-13<br>5-14-13 |
| F 505 SS=D | 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS<br><br>The facility must promptly notify the attending physician of the findings.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that the resident's physician was notified promptly of the laboratory test results for one of 17 sampled residents (Resident 11). This failure had the potential to cause a delay in proper medical services to meet the resident's need.<br><br>Findings:<br><br>A review of the Admission and Discharge Summary indicated Resident 11 was admitted to the facility on June 3, 2011, with diagnoses that included hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), anxiety and depression.<br><br>A physician's order dated August 4, 2011, indicated to draw a digoxin level (a type of blood test used to monitor the concentration of the medication, digoxin, which is used to treat | F 505 | | |

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| F 505 | Continued From page 29<br>congestive heart failure and to slow the heart rate in patients with atrial fibrillation in the blood) every six months. The physician's order specifically indicated to do the digoxin level for the months of February and August.<br><br>A review of the laboratory test results revealed the laboratory tests for the month February 2013, was not in the clinical records. The laboratory test for August 2012, indicated the following abnormality: digoxin 0.2 nanograms/milliliter (ng/ml)Low (normal range was 0.8 ng/ml to 2.0 ng/ml. During an interview with Registered Nurse (RN) Supervisor 1 on April 13, 2013 at 11 a.m., she stated the laboratory tests should have been completed as ordered by the physician and the physician should have been notified promptly of the results.<br><br>During another interview with the RN Supervisor on April 13, 2013 at 11 a.m., she reviewed the clinical record and was unable to find the laboratory test results for the digoxin level in the resident's clinical record. The RN Supervisor then stated that the laboratory test was drawn and completed on February 4, 2013, but the results were not filed in the clinical record.<br><br>A review of the laboratory test result dated February 4, 2013, faxed to the facility by the laboratory on April 13, 2013, indicated a digoxin level of 0.2 ng/ml Low, which was again below the normal range. During an interview with the RN Supervisor, she stated that the digoxin level was drawn at the same time with the other laboratory tests but the result was not available at that time. RN Supervisor stated she would notify the resident's physician immediately of the abnormal | F 505 | F505<br>A) Immediate corrective action for residents identified as being affected: The attending physician was immediately notified of the lab results, there was no change in orders based on the results.<br>B) Process of identifying other residents with the potential to be affected: Resident records were reviewed and lab results were verified as completed on 5-14-13<br>C) Systemic measures to prevent recurrence: Lab tests and test results will be audited on a daily basis to insure that the results are reported to attending physician.<br>D) How system changes will be monitored:<br>Lab audits will be presented to the quality assurance committee each month to verify that only completed | 4-14-13<br>5-14-13<br>5-14-13 |

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| F 505 | Continued From page 30<br>result.<br><br>The facility's undated policy and procedure titled " Laboratory Procedures, " indicated: the laboratory faxes the results, the facility notifies the attending physician of results by: faxing laboratory results to the attending physician's office, follow up and direction, whenever laboratory values require immediate intervention and the unit secretary files laboratory results in chart." | F 505 | results are being reported and that attending physicians are notified of the results.<br>E) Date deficiency was corrected: 5-14-13 | 5-14-13<br>5-14-13 |
| F 518 SS=E | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to train the staff on the facility's emergency procedures, which could delay the staffs' response time to emergency situations. Two of six staff did not know the location of the facility's gas shut-off valve, that the facility's emergency generator would provide electricity to the red electrical outlets (during a power outage), and the facility's evacuation plan in case of an earthquake.<br><br>Findings:<br><br>On April 11, 2013 at 8:15 p.m., the evaluator reviewed the facility's disaster manual. This | F 518 | F518<br>A) Immediate corrective action for residents identified as being affected: Staff were immediately instructed that the generator provides electricity to the red electrical outlets , the location of the gas shut off, and how to evacuate in case of an earthquake.<br>B) Process of identifying other resident with the potential to be affected: Inservice was provided to Woods Health Services staff on disaster preparedness., including that the generator provides | 4-15-13 |

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| F 518 | Continued From page 31<br>manual indicated that the facility's gas shut-off valve was located at the north side of the facility (near the rehab room), the emergency generator would provide electricity to the red electrical outlets (during a power outage), and staff should evacuate the residents to the facility's north side parking lot in case of an earthquake.<br><br>On April 11, 2013 at 9:05 p.m., a 3 p.m. to 11 p.m. shift licensed vocational nurse stated that there was no gas shut-off valve and she did not know that the emergency generator would provide electricity to the red electrical outlets (during a power outage).<br><br>On April 12, 2013 at 6:10 a.m., an 11 p.m. to 7 a.m. shift certified nursing assistant stated that staff should keep residents inside the facility when an earthquake occurs.<br><br>On April 13, 2013 at 10:45 a.m., the evaluator conducted an interview with the administrator regarding the staff interviews for emergency procedures. During this interview, the administrator was informed that two of six staff did not know some of the emergency procedures. The administrator stated all the staff would be in-serviced on the facility's emergency procedures as soon as possible. | F 518 | electricity to the red electrical outlets , the location of the gas shut off, and how to evacuate in case of an earthquake.<br>C) Systemic measures to prevent recurrence:<br>Associates will receive training on emergency preparedness upon hire and every 6 months.<br>D) How system changes will be monitored:<br>New hire training records will be reviewed to verify that emergency preparedness training took place. This review will be documented and presented to the quality assurance committee on a monthly basis to insure the effectiveness of the process.<br>E) Date deficiency was corrected:<br>4-30-13 | 4-30-13<br>4-30-13<br>4-30-13 |