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

CORRECTED COPY

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 a recertification survey conducted from 7/30/12 through 8/3/12. The facility was licensed for 103 beds. The census was 95 during the survey with 1 bedhold. There were 19 sampled residents. Representing the California Department of Public Health: 16555, Health Facilities Evaluator Nurse; 25076, Health Facilities Evaluator Nurse; and 25721, Health Facilities Evaluator Nurse.	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 the conclusions set forth on the Statement of Deficiencies. This plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq." [redacted]	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AUG 30 2012 L&C DIVISION SAN JOSE F157 The facility shall notify the physician and document when there is a change that has the potential for requiring physician intervention that affects the resident's physical health due to an adverse consequence. ➢ Corrective action was accomplished by: Resident #5's physician was notified of the missed appointments on 08/01/12 by MDS Coordinator. IDT meeting with physician was held on 08/02/12 to discuss further plan of care. Resident #5's chart was updated on 08/03/12 to reflect ongoing POC.	8/1/12 8/2/12 8/3/12

LABORATOR[redacted] (X6) DATE 8/28/12

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

POC accepted [redacted] 9/10/12 7:20AM
[redacted] Administrator 9/10/12 7:40 AM voice mail

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of four missed appointments for outside physical therapy, occupational therapy and speech therapy for one of 19 sampled residents (5). Findings: Resident 5 was admitted to the facility with diagnoses including cerebral vascular accident (CVA, rapid loss of brain function due to disturbance in blood supply to the brain). The Minimum Data Set (MDS, an assessment tool) dated 7/4/12, indicated Resident 5 was severely impaired in cognitive skills for daily decision making and was total assistance in activities of daily living (ADL). The clinical record for Resident 5 was reviewed on 8/1/12. The physician's order dated 3/8/12, indicated physical/occupational evaluation and treatment at acute care hospital outpatient rehabilitation diagnoses CVA. The physician's order dated 4/19/12 indicated speech therapy evaluation and treatment as indicated at acute care hospital outpatient rehabilitation treatment.	F 157	➢ The facility will identify other residents having the potential to be affected by the same deficient by: All appointments will be discussed in the morning stand-up meeting daily. A confirmation call is placed to the patient's responsible party that night before appointment. The corrective action that we took was: On 08/01/12 licensed staff were in-serviced by DON re: documentation of all appointment including if an appointment is missed and notification to physician for all missed appointments. ➢ The following systematic changes/measures were put in place to ensure that physician is notified of any change that has the potential for requiring physician intervention that affects the resident's physical health due to an adverse consequence and that it is documented: Strong collaboration between Out-Patient Rehab office and the facility will be managed by Social Services Director and MDS Coordinator who will ensure resident returns with the next appointment date. If not, a call will be placed no later that the following day to the Out-Patient Rehab office for follow through. ➢ Social Services Director will coordinate with the Receptionist to ensure that residents attend appointments and will follow-up any missed appointments and collaborate with IDT if further POC is needed. ➢ The quality assurance system the facility put in place to monitor ensuring the correction is achieved and sustained is: Our Social Services Director will coordinate with our Receptionist to ensure that residents attended their appointments. All residents missing their appointments will be documented by the Social Services Staff. That information will be presented by SS. Dept. and discussed at the monthly QA &A meeting for 6 months for analysis of the effectiveness of the corrective action, preventative measures, trends and further recommendations. ➢ Corrective Action: In-service was initiated on 08/01/12 and completed on 08/09/12.	8/1/12 8/1/12 8/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 157	Continued From page 2 The physical therapy treatment notes from the acute care hospital outpatient rehabilitation hospital indicate on 6/29/12 and 7/2/12 "patient no show". The nurse notes dated 7/18/12 at 11:30 a.m., indicated there were two appointments scheduled for outpatient therapy appointments at the acute care hospital on 7/19/12 and 7/26/12. During interview and record review with licensed nurse G (LN G) on 8/1/12 at 9:45 a.m., she stated the last two appointments scheduled on 7/19/12 and 7/26/12 for outpatient therapy for Resident 5 were missed because the family member scheduled to accompany the resident did not show up. She stated there was no documentation in the clinical record indicating the resident missed the appointments or of staff notifying the physician concerning the missed appointments on 7/19/12 and 7/26/12. She stated she was not aware Resident 5 had missed the appointments scheduled on 6/29/12 and 7/2/12. She stated she could not find documentation indicating Resident 5's physician had been notified of the missed appointments on 6/29/12 and 7/2/12. She stated when a physician's order is written the physician should be notified if the order is not followed.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241	F241 The facility shall provide care for residents in an environment that maintains each resident's dignity and respect in full recognition of their individuality.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 241	Continued From page 3 by: Based on observation, interview and record review, the facility failed to ensure one of 19 sampled residents (4) and three nonsampled residents (20, 21, and 22) were treated with dignity and respect when signs with residents' clinical information and care instructions were posted in their rooms in view of other residents and visitors. Findings: During the initial tour with licensed nurse J (LN J) on 7/30/12 at 1:10 p.m., the following were observed: 1. Resident 4 had his name and care instructions for showering every other day Monday, Wednesday, Friday , before shower apply neutral lotion and hold 5 minutes then shower, dry body, then put lotion again was posted on his outside closet door. During an interview with Resident 4 on 7/30/12 at the same time, he stated the nurses placed the sign on his closet door to remind them what to do. 2. Resident 22 had her name and care instructions indicating, "must have her compression stockings on in the morning and off in the evenings. Please be sure this happens. Thank you treatment nurse". The care instruction sign was posted over her bed. During an interview with LN J on the same date and time he stated, "looks like personal information to me" and should not be posted where other residents and visitors can see. 3. During an observation on 7/30/12 at 12: 42	F 241	➢ All postings that were at the head of the beds were removed by DSD and MDS Coordinator on 07/30/12 in rooms 4, 20, 21, and 22 and placed in the covered clipboard at the foot of each residents' beds. ➢ The facility identified other residents having the potential to be affected by the same deficient practice by: Conducted room rounds throughout entire facility by Administrator, DON, DSD, housekeeping supervisor and therapy manager on 07/30/12. The corrective action that we took was: Placing any signs or postings in the covered clipboard at the foot of each resident's bed. ➢ The following systematic changes/measures that were put in place to ensure that does not occur again was: All staff were in-serviced on dignity and respect of the individual started 07/30/12 and completed 08/01/12 by DSD. In-service specifically was that residents' personal information that needed to be placed at bedside should be placed in the covered clipboards at foot of each bed. ➢ The quality assurance system the facility put in place to ensure the correction is achieved and sustained is: Daily QA&A rounds by department heads, nursing staff, Administrator and therapy staff shall monitor compliance. Any and all discrepancies found will be brought to the QA&A monthly committee meeting by the Administrator to be discussed. Upon admission, family will receive instructions from the Admissions Coordinator about posting signs in the proper location at bedside. This information will be also to given to all staff upon hire and will be in-serviced annually by the DSD.	7/30/12 7/30/12 7/30/12 8/1/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 241	Continued From page 4 p.m., Resident 20 was in her bed. On the wall adjacent to her bed a prominent sign was posted which read "Per Activity requests [Resident 20] up to the wheelchair every Monday, Wednesday, and Friday." Resident 21 shared the bedroom with Resident 20. On the wall adjacent to her bed a prominent sign was posted which read "Please keep bed elevated at 40 degrees." During an interveiw on 7/30/12 at 1 p.m., licensed nurse G was shown the signs posted on the walls adjacent to Residents 20 and 21. She stated the facility policy was to cover resident care instructions so they were not visible, unless having them visible was the preference of the resident or the resident's responsible party.	F 241	➢ The following dates when the corrective action was completed was 07/30/12 and 08/01/12.	7/30/12 8/1/12
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically-related social service for one of 19 sampled residents (5). For Resident 5 the facility failed to coordinate communication with acute care outpatient therapy and failed to follow-up on Resident 5's four missed appointments with the outpatient therapy. Findings: Resident 5 was admitted to the facility with	F 250	F250 The facility shall provide medically-related social services to maintain the highest practicable physical well-being of each resident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 250	Continued From page 5 diagnoses including cerebral vascular accident (CVA, rapid loss of brain function due to disturbance in blood supply to the brain). The Minimum Data Set (MDS, an assessment tool) dated 7/4/12, indicated Resident 5 was severely impaired in cognitive skills for daily decision making and was total assist in activities of daily living (ADL). The clinical record for Resident 5 was reviewed on 8/1/12. The physician's order dated 3/8/12 indicated physical/occupational evaluation and treatment at acute care hospital outpatient rehabilitation diagnoses CVA. The physician's order dated 4/19/12 indicated speech therapy evaluation and treatment as indicated at acute care hospital outpatient rehabilitation treatment. During interview and record review with licensed nurse G (LN G) on 8/1/12 at 9:45 a.m., she stated the physician for Resident 5 had requested the progress records for the outpatient therapy the resident was receiving. She stated the progress notes for the outpatient physical therapy, occupational therapy and the speech therapy were FAXED to the facility on 7/2/12 and placed on the clinical record. She stated the facility did not have the notes from the acute care outpatient therapy before the request from the physician even though Resident 5 had been attending outpatient therapy since the physician's order written on 3/8/12. The acute care hospital outpatient physical therapy treatment notes dated 6/27/12, indicated, "overall, patient making slow progress but is making progress and has ability for some gains." The physical therapy treatment notes from the	F 250	➢ The corrective action is: As of 08/03/12 Social Services Director will monitor this resident's transportation arrangement with the family and out-pt rehab office. Social Services conducted an IDT meeting with the family of the resident that missed her appointment on 8/09/2012. ➢ The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing the appointments, scheduled for the following day to ensure that transportation and appropriate designated personnel are in place. ➢ The following systematic changes/measures that were put in place to ensure that deficient practice does not occur again is; receptionist will provide daily appt listings to Social Services dept. MD will be called if appointments are missed and social services will meet/call family to discuss missed appt and will be documented by Social Service director in the medical record. If family member is unable to attend appointment, the facility will assign a staff member to attend with resident. ➢ The quality assurance system the facility put in place to monitor that correction is achieved and sustained is: Social Service Director will keep a log for missed appointments for all residents and will report findings at monthly QA&A meetings. Social Services will meet with IDT when trending occurs. ➢ The following dates when the corrective action was completed was 8/9/12	8/3/12 8/9/12 8/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 250	Continued From page 6 acute care hospital outpatient rehabilitation hospital indicated on 6/29/12 and 7/2/12 "patient no show". The nurse notes dated 7/18/12 at 11:30 a.m., indicated there were two appointments scheduled for outpatient therapy appointments at the acute care hospital on 7/19/12 and 7/26/12. During a continued interview with LN G on the same date and time, she stated the last two appointments scheduled on 7/19/12 and 7/26/12 for outpatient therapy for Resident 5 were missed because the family member scheduled to accompany the resident did not show up. She stated she was not aware Resident 5 had missed the appointments scheduled on 6/29/12 and 7/2/12 until she reviewed the outpatient therapy notes at this time. During an interview with the director of social services on 8/1/12 at 10 a.m., she stated she "only heard in passing" that Resident 5's family was unable to attend appointments with the resident to the outpatient therapy appointments and the resident had missed the four appointments. She stated there should have been an interdisciplinary team meeting (IDT) to determine if staff could attend the out patient therapy with Resident 5, if the family was unable to attend, so the resident would not miss the therapy appointments. She stated there was an IDT meeting on 7/18/12, but there was no documented evidence indicating the missed four appointments were discussed or a discussion with family concerning an arrangement for staff to attend outpatient therapy with the resident when family are unable to attend.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 250	Continued From page 7 The facility's job description for social service director dated 10/2010, indicated the social service director directs and coordinates resident's appointments including transportation. Assures that a thorough and timely psychosocial history and assessment are completed for each resident to identify problems, issues or needs that are addressed through IDT and care plan process.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a	F 279	F279 The facility shall assess and develop, review and revise the resident's comprehensive plan of care. The care plan shall describe the services that are to be furnished to attain or maintain the resident's highest practical physical well-being. ➢ Corrective Action: Resident #6's care plan was updated on 08/03/12 by MDS Coordinator. Resident #7's care plan was updated on 08/03/12 by MDS Coordinator. Resident #12's care plan was updated on 08/03/12 by ADON. Resident #18's care plan was updated on 08/03/12 by ADON. ➢ Identification: All residents have been identified to potentially have the possibility to be effected by the same deficient practice. A thorough chart review will be conducted upon every quarterly MDS Assessment by IDT along with Care Plan Updating by IDT.	8/3/12 8/3/12 8/3/12 8/3/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 279	Continued From page 8 comprehensive careplan for four of 19 sampled residents (6, 7, 12, and 18). For Resident 6, the facility failed to develop a care plan for the application of a left splint to hand every morning by the restorative nurse assistant (RNA). For Residents 7, 12, and 18 with pacemakers (a device implanted on the chest wall to help control abnormal heart rhythms) there were no care plans developed with parameters, measurable objectives and timetables to meet the residents' medical needs in the event of malfunction. Findings: 1. Resident 6 was admitted with diagnoses including left hemiparesis (weakness left side). The clinical record was reviewed on 7/31/12. The physician's order dated 3/18/11, indicated RNA to apply left splint to hand every morning to be worn three to six hours as tolerated. During an observation on 7/31/12 at 12:15 p.m., Resident 6 was observed sitting in her room and a splint was observed on her left wrist. She stated the splint was there to keep her fingers from closing. She stated the nurse applies the splint in the morning and she wears the splint for most of the day until it is removed in the afternoon. During an interview and record review with licensed nurse F (LN F) on 8/1/12 at 8:20 a.m., she stated staff is to monitor the skin integrity (condition of the skin) under the left hand splint every shift. She stated there was no documentation on the RNA care plan or a separate care plan indicating the RNA splint application to Resident 6's left wrist. She stated the application of the splint is part of Resident 6's care and should be part of the care plan.	F 279	➢ The following systematic changes/measures that were put in place to ensure that this deficient practice does not occur again are as follows: 1. Admitting nurse to review H&P, Physician's Orders, and will Care Plan all diagnosis and medications to reflect an accurate care plan. 2. MDS Coordinator will review the chart including progress notes while completing MDS Assessments and update care plan to reflect that all diagnosis/special needs are care planned. 3. Licensed nurse to note all incoming progress notes and to add new diagnosis on Care Plan. 4. LTC MDS nurse along with IDT will review and update care plan quarterly to include diagnosis and medications through chart review including progress notes. 5. DON in-serviced all licensed nurses, ADON, MDS coordinators, and IDT the importance of ongoing care plan management on 7/31/12-08/15/12. ➢ The quality assurance system the facility put in place to ensure the correction is achieved and sustained is: Medical Records shall audit care plans after each quarterly care plan meeting for 1 month. The findings shall be reported to IDT for correction. The audit tool will be given to the Administrator same day of each audit. The findings will also be brought to the monthly QA&A committee meeting by the Medical Records Supervisor for analysis of the effectiveness of the corrective action, preventative measures, trends and if they recommend to continue same process or to change plan of action for the following months to come. ➢ Completion date: 08/15/12.	7/31/12 8/15/12 8/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 279	Continued From page 9 2. Resident 7's clinical record was reviewed on 8/2/12. The history and physical dated 11/29/11 indicated Resident 7 had a cardiac pacemaker. During an interview and record review with licensed nurse G (LN G) on 8/2/12 at 10:12 a.m., she stated the resident is seen by a cardiologist (a physician specializing in disorder of the heart). She stated she was not aware Resident 7 had a cardiac pacemaker. She stated there was no care plan indicating the resident had a pacemaker and if a resident has a pacemaker it should be part of the care plan. 3. Resident 18's clinical record was reviewed on 8/3/12. The history and physical dated 4/24/12, indicated Resident 18 had a cardiac pacemaker. During an interview and record review on 8/3/12 with licensed nurse A (LN A) on 8/3/12 at 10:20 a.m., she stated there was no care plan for the pacemaker on Resident 18's clinical record. She stated a care plan is usually triggered and initiated by the MDS nurse during assessment of the resident. 4. Resident 12's clinical record review on 8/2/12 at 11 a.m. her admission skin assessment dated 7/18/12, indicated she had a history of open heart surgery and a cardiac pacemaker placement. During clinical record review with licensed nurse A (LN A) on 8/2/12 at 2:45 p.m., there was no care plan developed for pacemaker. Review of the facility's 7/08 policy, "Care of a Permanent Pacemaker" on 8/3/12, it indicated to	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 279	Continued From page 10 include an entry for pacemaker on the resident's Care Plan, and enter type of pacemaker, date of insertion, rate, and pacemaker check lab phone number, if applicable.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the residents' environment remained free of accident hazards, when, 1) An electric fan was in the corridor with its cord unplugged and lying on the floor outside Room 10. This was a potential trip hazard; 2) Trim molding which was above the handrail near Room 16 was sharp and chipped with the potential to cut residents using the handrail. Findings: 1. During the environmental observation on 7/30/12 at 12:45 p.m., and on 7/31/12 at 8:40 a.m., an electric fan was noted in the corridor by Room 10. The cord was unplugged and laid straight on the floor. During an interview on 7/30/12 at p.m., the maintenance supervisor stated the fan should not be there.	F 323	F323 The facility shall ensure that the environment remains free of accident hazards to prevent accidents. ➢ Corrective Action: The fan was removed from hallway and moved to storage due to it not being in use by Maintenance Supervisor on 07/30/12. The piece of trim was removed by room 16 by Maintenance Supervisor on 08/03/12. ➢ Identification: All areas of the facility has the potential for having same defiant practice. Therefore daily rounds will be conducted by all supervisors and will give all equipment not in use to maintenance department to place in proper storage. Monthly rounds shall be conducted and documented by maintenance department to observe any sharp edged molding found throughout facility and promptly repaired or replaced. ➢ Measures to prevent recurrence: A monthly preventative maintenance check off sheet will be used by the department to log any areas that need to be addressed to maintain the facility free of accidents/hazards.	7/30/12 8/3/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 323	Continued From page 11 During an interview on 7/31/12 at 2 p.m., Resident 23 stated for two days she had observed the fan in the corridor. The facility's 7/08 policy "Resident Safety," indicated corridors should be unobstructed, except when equipment is in use. It also indicated to store equipment when not in use. 2. During the environmental inspection with the maintenance supervisor on 7/31/12 at 8: 30 a.m., a trim molding above the handrail by Room 16 was observed to be chipped with sharp edges. During further interview, the maintenance supervisor stated the sharp edged molding needed to be removed. The facility's 3/08 policy "Environmental Services Safety," indicated a well maintained Care Center is a safe Care Center and residents are dependent on the upkeep and maintenance of all areas of the Care Center.	F 323	Maintenance Supervisor in-serviced the housekeeping and nursing department on 07/30/12, 7/31/12 and 8/02/12 to report and log into the maintenance binder at each nursing station any daily hazards found. The binder will be looked at by the maintenance department 5 days a week (M-F) and addressed timely. ➢ Maintenance Department will be responsible for all equipment not in use to be removed from the facility. All areas found and repaired on a monthly basis will be brought to the monthly QA&A Meeting and discussed for further recommendations if needed. ➢ Completion date: 8/24/12.	7/30/12 7/31/12 8/2/12 8/24/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	F425 The facility shall provide routine and emergency drugs and biologicals to its residents including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. ➢ Corrective Action taken was: On 08/02/12 physician was notified by DON & MD order was obtained stating, "may give all meds upon return on scheduled dialysis days."	8/2/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs of one of 19 sampled residents (15). For Resident 15, the facility failed to ensure medications were coordinated between the facility and the dialysis center prior to dialysis and to ensure medications were administered in a timely manner. Findings: The clinical record for Resident 15 was reviewed on 8/2/12. The physician's order dated 7/8/11 indicated dialysis treatment Monday, Wednesday and Friday at 5 a.m. at an outside dialysis clinic. The medication administration record (MAR) for the months of June 2012 and July 2012 indicated the medications on days of dialysis were administered at 9 a.m. even when Resident 15 was at the dialysis center at that time. During an interview and record review with the director of nurses (DON) on 8/2/12 at 3:55 p.m., she stated the scheduled 9 a.m. medications were Nepro (a nutritional supplement) one 8 ounce can, Ropinirole 0.25 milligrams (mg) for	F 425	➢ Identification: The facility identified one other dialysis resident which may have same potential for this deficient practice and the same order was obtained also on 08/02/12 by DON. ➢ Measures put into place to make sure that this process will not reoccur included: The Admission's Nurse will request an MD order on newly admitted Dialysis residents, to give medication post dialysis return if needed. In-service was initiated 08/02/12 and completed on 08/10/12 by DON to ADON/Admission's Nurse and all Charge Nurses. The Medical Records Dept. will conduct a 24 hr audit on each newly admitted resident to monitor compliance. ➢ The Quality Assurance system that the facility put in place to monitor that the correction is achieved and sustained is: The DON, ADON and Medical Records Dept. will monitor and review orders for all new dialysis encounters for correct physicians medication orders. All dialysis charts will also be reviewed by the DON monthly. Any new findings will be reported by the DON to the QA&A committee monthly for 6 months for analysis of the effectiveness of the corrective action, preventative measures, trends and further recommendations if needed. ➢ Completion date: 08/10/12.	8/2/12 8/2/12 8/10/12 8/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 13 Parkinson's disease, Nephrovite (a vitamin)one tablet daily, Lasix (a diuretic) 20 mg for chronic renal disease, Metoprolol 100 mg for hypertension and aspirin (for prevention of blood clotting) 81 mg for prophylaxis. She stated the resident was given the scheduled 9 a.m. medications when he returned from dialysis usually around 10:30 to 11 a.m. She stated the scheduled 9 a.m. medications should not be given that late after they are due (one and one half to two hours) and the nurse should notify the physician when the medications are not given in a timely manner. She stated the licensed nurse should have called the physician to get an order to adjust the scheduled 9 a.m. medications on Resident 15's dialysis days. She stated the licensed nurse failed to notify the physician for the adjustment of medications.	F 425		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the attending physician regarding one of 19 sampled residents' (7) abnormal laboratory results. Findings: The clinical record for Resident 7 was reviewed on 8/2/12. The medication regimen review (MRR) dated 7/16/12, indicated Resident 7 was receiving Seroquel (medication for treatment of depression, bipolar disorder and dementia) and as per clinical pharmacology monitoring parameters, there	F 505	F505 The Facility shall notify the attending physician of lab results. ➢ Corrective action was accomplished for resident by: The ADON notified physician on 08/02/12 upon receiving lab result from Muir Lab. ➢ Identification: The facility identified that all residents that have labs drawn could have potential for same deficient practice. A thorough audit for months of July and August was conducted by ADON and DON 08/02/12 and completed on 8/04/12.	8/2/12 8/2/12 8/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555060	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906

(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 505	Continued From page 14 should be a blood glucose and liver function tests completed. The physician agreed and a fasting blood sugar and liver panel were ordered on 7/24/12. During an interview and record review with licensed nurse A (LN A) on 8/2/12 at 9:10 a.m., she stated Resident 7 had refused to have his blood drawn on 7/24/12 and the blood draw was done on 7/26/12. She stated there were no laboratory results in the clinical record. She stated she had the laboratory results FAXED to the facility and the albumin level was low. She stated there was no documentation on the clinical record indicating the laboratory results were relayed to the physician. She stated the evening shift nurse should be checking to make sure the laboratory testing is completed and phoned or FAXED to the physician.	F 505	➢ Measures to prevent reoccurrence: A resident log will be kept in the Lab Book of all labs done. Day and Pm shift licensed nurses will review and audit log form initialing and dating when they have received lab results. They will then properly notify physician regardless of lab findings. Night shift nurses will also follow up on labs if facility has not received them by the time their shift begins. DON will be informed by Licensed staff daily if lab results do not return timely. ➢ Facility plans to monitor and incorporate into the Quality Assurance system: By having the DON and ADON reviewing/auditing lab books daily to ensure compliance. . Any findings will be brought to monthly QA&A committee meeting. The DON will present findings for the next 12 months for analysis of the effectiveness of the corrective action, preventative measures, trends and further recommendations.. ➢ In-service was initiated by DON to all three shifts of Licensed Nurses 08/02/12 and completed 08/10/12.	8/2/12 8/10/12