POC accepted 6-6-12 @ 4:04pm JL Jam

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

PRINTED: 05/24/2012
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
	556832	A. BUILDING _____ B. WING _____	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA BALDWIN STOCKER HOME	527 S VALINDA AVENUE WEST COVINA, CA 91790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: 30258 27680 16279 Total Resident Population: 38 Total Resident Sample: 10	F 000		
F 241 SS=E	Highest Scope and Severity: E 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 by: Based on observation and interview the facility failed to promote care for residents in a manner and in an environment that maintained the resident's dignity and respect for four randomly selected residents (RSR 11,12, 13, 14). Four different staff were observed standing over residents while assisting them to eat. This had the potential to not honor the resident's dignity. Findings: During a dining observation on April 26, 2012 at	F 241	**Facility will ensure resident's dignity and respect is maintained or enhanced in full recognition of his or her individuality.** 1. All residents received dignity in all dining areas. *By DSD* 4/28/2012 2. In-service given to staff to ensure residents receive dignity while dining. *By DON or DSD* 5/9/2012 Weekly and random rounds will be made to monitor residents' mealtime. *By DON or DSD*	

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2012 AUG 23 AM 10:08
HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ernest Rockrise | TITLE: Administrator | (X6) DATE: 6-1-2012

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 241	Continued From page 1 6:00 p.m., in the Rosebud Room at Station 1, two certified nursing assistants (CNAs 3 and 4) were observed standing while feeding RSR 11 and 13. In another dining observation on the same day at approximately 6:10 p.m., in the Station 2 dining room, the social services director and CNA 2 were observed standing while feeding RSR 12 and 14. All four residents observed have cognitive impairments and require total assistance with eating. In an interview on April 27, 2012 at 7:40 p.m., CNA 2 stated it is preferable to sit down while feeding a resident in order to be at the resident's level and be able to make eye contact. On April 27, 2012 at 8:45 p.m., during an interview, the director of staff development (DSD) stated the staff is supposed to be seated while feeding a resident. The DSD stated CNAs are taught in school they should be seated while feeding a resident. The DSD also stated she provides in-services for the CNAs in which she teaches the proper way to feed residents. The DSD stated "It's a dignity issue", sitting while feeding a resident and having eye contact encourages social interaction. In an interview on April 28, 2012 at 9:20 a.m., the director of social services (DSS) stated staff should be sitting down while feeding residents, the DSS stated she did not sit down because there were no chairs in the dining room at the time she was feeding the residents. A review of the policy titled, "Dignity", revised October 2009, indicated each resident shall be cared for in a manner that promotes and	F 241		

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F 241	Continued From page 2 enhances quality of life, dignity, respect, and individuality.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the 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 off premise activities (outings) for the residents. Four of four residents interviewed stated the facility did not provide outings for the residents. This had the potential to result in limited social experiences and or insufficient enjoyable outside of the health facility experiences for the residents. Findings: During a group meeting on April 27, 2012 at 6:45 p.m., four of four alert and oriented residents stated the facility did not provide outings for any of the residents. In an interview with the activities director on April 28, 2012 at 11:55 a.m., the activities director was asked if the facility provided any outings for the residents. The activities director stated they did not have outings. According to the activities director the last outing had been "A walk to an ice cream store about one year ago". When asked if there was any documentation indicating when the	F 248	**The facility will schedule, plan, document and provide off-premise (outings) for the residents.** The resident council will be consulted for where the outing will be planned. *By Activity Director* Outings will be documented in the resident's attendance records and a log will be kept. *By Activity Director* Outings will be reviewed on an ongoing basis. *By Administrator* Outing reports will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	5/1/2012

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F 248	Continued From page 3 last outing had taken place, the activities director stated there was no documentation. Review of the facility's undated policy, "Outdoor Activities", indicated it is the policy of this facility to provide activities for the residents outside of the facility to encourage socialization of the residents by providing a meaningful and enjoyable recreational experience, outside of the health facility experience.	F 248		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to provide the necessary care and services for one resident who leaves the facility to obtain dialysis from an outside entity (Resident 1) in a total sample of 10 residents. The facility staff failed to monitor and document the resident's status before and after receiving dialysis treatment. This had the potential to result in a delay of identifying possible complications from dialysis treatment. Findings: A review of the Admission and Discharge	F 309	**Facility will provide the necessary services to attain and maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.** 1. Resident #1: Documented assessment of residents' status pre and post dialysis. *By Licensed Nurse* 5/9/2012 2. Facility audited all residents' charts to ensure proper documentation of dialysis residents. *By MRD* 5/10/2012 3. In-service provided to licensed nurses for assessment and documentation guidelines for dialysis residents. *By DON* 5/9/2012 Monthly audit for residents receiving dialysis to ensure proper documentation pre and post dialysis. *By MRD*	

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F 309	Continued From page 4 Summary of Resident 1 indicated the resident was admitted to the facility on April 20, 2012, with diagnoses that included end stage renal (kidney) disease, congestive heart failure (a condition in which the heart can no longer pump enough blood to the rest of the body), and hypotension (low blood pressure). There was a physician's order dated April 20, 2012, indicating that the resident is to receive hemodialysis (a procedure for removing metabolic waste products or toxic substances from the bloodstream by dialysis) treatment three times a week at an outpatient dialysis center (exact days of the week were not specified). During an interview with licensed vocational nurse (LVN) 1 on April 27, 2012, at 7:40 p.m., she stated that the status of dialysis residents must be assessed before they leave the facility to obtain dialysis and upon their return to the facility. LVN 1 stated the nurse would document his or her assessment on the nurse's notes including vital signs and any signs of complications from the dialysis treatment. However, there was no documented evidence the resident's status was assessed before and after each dialysis treatment including vital signs and assessment of the resident's arteriovenous (AV) shunt (a U-shaped plastic tube inserted between an artery and a vein usually to allow repeated access to the arterial system for hemodialysis). In addition, there was no plan of care developed to reflect the resident's needs related to end stage renal disease and dialysis care. On April 28, 2012, at 11:20 a.m., during an interview with the director of nursing (DON), she	F 309	Results of audit will be monitored to ensure correction is achieved and sustained on a monthly basis. *By DON*	

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F 309	Continued From page 5 stated that Resident 1 is the only dialysis patient in the facility and that the facility did not admit a lot of dialysis residents. When the surveyor brought up the issue with the DON, she stated she would take care of the problem. The facility's policy and procedure titled "End-Stage Renal Disease, Care of a Resident with" dated October 2010, indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Staff caring for resident with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis, signs and symptoms of worsening condition and/or complications of ESRD, and the care of grafts and fistulas. The policy indicated that the resident's needs related to ESRD/dialysis care would be reflected and addressed on the resident's comprehensive care plan.			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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.	F 315	Facility will ensure that residents who enter the facility without an indwelling catheter are not catheterized unless the clinical condition demonstrates that catheterization was necessary. 1. Resident #3: MD and hospice were contacted and order received for antibiotics for UTI. Superpubic catheter was secured to resident's leg and drainage bag was positioned below the bladder level. *By Licensed Nurse*	4/28/2012

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F 315	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to properly monitor an indwelling urinary catheter (a tube placed through the urethra into the bladder or surgically placed through the wall of the belly into the bladder to drain urine)for a resident (Resident 3) and failed to ensure the use of a urinary catheter was justified for a resident (Residents 4), for two of two residents with indwelling catheters out of 10 sampled residents. Resident 4 had a catheter re-inserted three days after it had been removed. There was no justification from the physician for the catheter being re-inserted. Resident 3's catheter was observed as having cloudy urine and thick sediments, the nurses did not notify the physician. In addition the catheter was observed hanging above the bladder and was not secured with a leg strap. This had a potential to result in improper use of a urinary catheter, delay in treatment for complications related to the use of catheters, and injury to the urethral meatus and urethra. Findings: a. Review of an admission, "Face Sheet", indicated Resident 4 was admitted to the facility on January 26, 2012 and re-admitted on February 8, 2012. The resident's diagnoses included brain damage and pneumonia (an inflammation of the lungs caused by an infection). A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated February 23, 2012, indicated the resident	F 315	2. Resident #4: MD was contacted and order received for diagnosis for use of indwelling catheter. *By Licensed Nurse* 3. Reviewed all residents for orders of indwelling catheter. There was one other resident with catheter: Catheter was secured to leg, drainage bag was positioned below bladder level and clear urine observed. Order for indwelling catheter with diagnosis was noted in chart. *By DON* 4. In-service provided to licensed nurses for proper documentation of indwelling catheters, including diagnosis, monitoring for UTI's, securing of catheters and maintaining drainage bag below bladder level. *By DON* Monthly audit for residents with indwelling catheter. *By DSD or DON* Results of audit will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	4/30/2012 5/1/2012 5/9/2012

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F 315	Continued From page 7 cognitive (mental) skills for daily decision making are severely impaired. The resident is totally dependant on staff for transfers, dressing, and personal hygiene. Review of a physician's order dated February 8, 2012, indicated to insert a urinary indwelling catheter size 16 to a closed drainage system (catheter tube that remains in the bladder continuously to drain urine). Review of a second physician's order dated March 10, 2012, indicated to discontinue the catheter. Three days later another physician's order dated March 13, 2012, indicated to re-insert the catheter size 16 to a closed drainage system. Review of a licensed nurse progress note dated March 10, 2012, indicated the urinary indwelling catheter was removed and the procedure was tolerated well by the resident. Review of another progress note dated March 11, 2012, indicated the resident was voiding and skin care was being provided post voiding. A third progress note dated March 13, 2012, indicated the physician had been notified regarding the residents increased need for assistance with voiding. According to the note the urinary catheter was re-inserted that day. Further review of the progress notes from March 10, 2012 through March 13, 2012, did not indicate any documentation from the licensed nurses that the resident was having trouble voiding or retaining urine after the catheter had been removed, on any of the days the resident did not have a catheter. Review of the "Nursing Assistant Daily Flow Sheet-Day Shift", for the month of March 2012, indicated the resident had three episodes of	F 315		

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F 315	Continued From page 8 voiding during the day shift on each of the following days, March 11,12, and 13, 2012. Review of another, "Nursing Assistant Daily Flow Sheet -Night Shift" for the month of March 2012, indicated the resident was incontinent of bladder. The flow sheet also indicated the resident had three episodes of voiding during the night shift on each of the following days March 11, 12, and 13, 2012. In an interview on March 27, 2012 at 5:40 p.m., registered nurse 1 (RN 1), stated she had asked the physician if Resident 4's urinary indwelling catheter could be removed. According to the RN, the physician agreed and the catheter was removed on March 10, 2012. According to the RN the catheter was re-inserted on March 13, 2012, because the resident was retaining urine. In an interview on April 28, 2012 at 11:25 a.m., the director of nursing (DON) was asked why the indwelling catheter had been re-inserted on March 13, 2012. The DON stated she did not know. When asked if there was any justification from the resident's physician for re-inserting the catheter. The DON stated a nursing progress note indicated there had been urine retention however there was no documentation from the physician regarding the catheter other than the order itself. When asked if the physician's order indicated a justification for re-insertion of the catheter the DON stated "No". The DON was asked if there had been any type of follow up after the catheter had been re-inserted, the DON stated "I don't know". The DON was also asked what the plan was for the resident and whether there would be another attempt at removing the catheter, the DON stated "I don't know, I'll have to	F 315		

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F 315	Continued From page 9 call the doctor to find out what she wants to do." In an interview on April 28, 2012 at 12:05 p.m., certified nursing assistant (CNA) 1 was asked about the March 2012, nursing assistant flow sheet-night shift. The CNA stated the number three written on March 11, 12, and 13, under the section bladder and incontinent meant the resident had voided three times on each of the days. According to the director of staff development (DSD) the facility did not have a policy that indicated a physician should have justification for writing an order to have a catheter inserted. b. On April 26, 2012, at 5:35 p.m., during the initial tour observation with the director of nursing (DON), Resident 3 was observed in bed awake and alert to his name. The resident had an indwelling urinary catheter draining cloudy, yellow urine with sediments (small particles floating in the urine) in the urinary catheter tubing. A review of the resident's Admission and Discharge Summary indicated the resident was admitted to the facility on February 25, 2012, with diagnoses that included dementia (loss of mental ability), chronic kidney disease, chronic airway obstruction, and dysphagia (difficulty swallowing with gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition or medication directly to the stomach). A review of a care plan dated February 25, 2012, indicated the resident had a suprapubic catheter (a urinary bladder catheter inserted through the skin about 1 inch above the symphysis pubis) due to a diagnosis of urinary retention and	F 315		

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F 315	Continued From page 10 obstruction. The care plan goal indicated the resident would have no signs or symptoms of infection within the next review date. The listed nursing interventions included to provide catheter care per protocol and to observe the resident for signs and symptoms of urinary tract infection (UTI). There was a physician's order dated February 27, 2012, indicating orders for a suprapubic catheter #22 french/5 cubic centimeter (cc) to closed drainage and to change the catheter every month and as needed (PRN) if leaking. Another physician's order dated April 2, 2012, indicated to cleanse the suprapubic catheter site with normal saline (sterile solution of sodium chloride) every shift and as needed and flush the catheter with 100 cc of normal saline daily and PRN occlusion. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated March 8, 2012 indicated the resident had short and long-term memory problems, was severely impaired in his cognitive skills for daily decision-making, rarely/never understood others and rarely/never made himself understood, and required total assistance from the staff with all activities of daily living. According to the MDS, the resident had an indwelling urinary catheter. During an observation on April 26, 2012, at 7:45 p.m., the resident was observed in bed with an indwelling urinary catheter draining cloudy, yellow urine with sediments. During multiple observations on April 27, 2012, at 4:55 p.m., 6 p.m., and 7:30 p.m., the resident's indwelling urinary catheter was observed draining	F 315		

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F 315	Continued From page 11 cloudy, yellow urine with thick sediments in the urinary catheter tubing and urinary drainage bag. The urinary catheter drainage bag was hanging on the upper right side rail of the resident's bed, positioned above the resident's bladder. Upon further observation the catheter tubing was observed not strapped or secured on the resident's thigh. On April 27, 2012 at 7:30 p.m., during an interview, the surveyor and licensed vocational nurse(LVN) 1 went inside the resident's room to check the resident's indwelling urinary catheter. LVN 1 acknowledged the presence of sediments in the urinary catheter tubing and drainage bag. LVN 1 stated the urinary drainage bag should be positioned below, and not above the resident's bladder. During a subsequent interview with LVN 1 on April 27, 2012, at 7:32 p.m., she reviewed the clinical record and was unable to find documented evidence that the resident was monitored for and his physician was notified of the cloudy urine with sediments in the indwelling urinary catheter tubing and drainage bag until April 27, 2012, at 2 p.m. On April 28, 2012, at 9:20 a.m., during an interview with the director of staff development (DSD), she stated that the urinary catheter drainage bag should be positioned below the resident's bladder and should be secured on the resident's thigh with a leg strap. The facility's policy and procedure titled "Catheter Care, Urinary" dated September 2006, indicated that the urinary drainage bag must be held or	F 315		

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	555832	A. BUILDING _____ B. WING _____	04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 12 positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The policy indicated to observe the resident for signs and symptoms of urinary tract infection and urinary retention and report findings to the supervisor immediately and to ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site (catheter tubing should be strapped to the resident's inner thigh).	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure that appropriate treatment and services were provided to one of two sampled residents (Resident 3) who had a gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition and medication directly to the stomach) in a total sample of 10 residents. The resident did not receive the GT feeding formula as ordered by the physician which had the potential to result in dehydration and metabolic abnormalities.	F 322	**The facility will ensure NG/GT residents receive 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.** 1. Resident #3: Enteral feeding was started at 4:00 pm as per MD order. *By Licensed Nurse* — 4/28/2012 2. Residents with enteral feedings were started timely as per MD orders. *By Licensed Nurse* — 4/28/2012 3. In-service to licensed nurses for administration of enteral feeding. *By DON* — 5/9/2012 Monthly and random audits for administration of enteral feedings. *By DON*	

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F 322	Continued From page 13 Findings: During the initial tour observation with the director of nursing (DON) on April 26, 2012, at 5:35 p.m., Resident 3 was observed in bed awake, alert to his name only. There was a bottle of Jevity 1 cal (feeding formula) observed hanging on a pole next to the resident. There was no enteral pump anywhere in the room and the feeding formula was not connected to the resident's GT. A review of the resident's Admission and Discharge Summary indicated the resident was admitted to the facility on February 25, 2012, with diagnoses that included dementia (loss of mental ability), chronic kidney disease, chronic airway obstruction, and dysphagia (difficulty swallowing with gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition or medication directly to the stomach). A care plan dated February 27, 2012, indicated the resident was at risk for altered nutritional status and/or dehydration related to tube feeding, swallowing problems, and terminal prognosis. The care plan goal indicated the resident would have no signs and symptoms of dehydration, and would receive adequate nutrition via tube feeding for 90 days. The listed nursing interventions included to observe the resident for signs and symptoms of dehydration and to administer the tube feeding as ordered. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated March 8, 2012, indicated the resident had short and long-term memory problems, was severely impaired in his cognitive (mental) skills for daily	F 322	Results of audit will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	

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F 322	Continued From page 14 decision-making, rarely/never understood others and rarely/never made himself understood, and required total assistance from the staff with all activities of daily living. According to the MDS, the resident had a feeding tube. A review of a physician's order dated March 15, 2012, indicated to administer Jevity 1.0 at 60 cubic centimeters per hour (cc/hr) for 22 hours via GT and enteral pump to provide 1320 kilocalorie (kcal) per 1200 cc in 24 hours. The order indicated to turn the enteral pump on at 4 p.m. During an observation on April 26, 2012 at 7:45 p.m., the resident was observed in bed awake but was not responding to the surveyor's questions. A bottle of Jevity 1 cal was observed hanging on a pole next to the resident and not connected to the resident's GT. There was no enteral pump observed anywhere in the room. During an interview with the registered nurse (RN) 1 on April 28, 2012 at 7:50 a.m., she stated that on April 26, 2012, at around 4 p.m. she turned on the enteral pump and connected it to the resident's GT to deliver Jevity 1 cal at 60cc/hr as ordered. According to RN 1, the enteral pump must be turned on at 4 p.m. and turned off at 2 p.m. the following day to complete the dose in 22 hours per physician's order. RN 1 could not explain how the feeding formula got disconnected from the resident's GT. On April 28, 2012, at 11:20 a.m., during an interview with the director of nursing (DON), she stated that she did not notice that the resident was not receiving the enteral nutrition of Jevity as	F 322		

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F 322	Continued From page 15 ordered by the physician during the initial tour with the surveyor. The facility policy and procedure titled "Gastric Tube Feeding via Continuous Pump" dated September 2004, indicated the purpose of the procedure is to provide nourishment to the resident who is unable to obtain nourishment daily. The nurse should verify that there is a physician's order for the procedure, review the resident's care plan and provide care for any special needs of the resident, assemble equipment and supplies needed, and ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or the facility. The nurse is to connect the infusion pump to the resident, set the rate, and push start to begin continuous feedings.	F 322		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 328	**Facility will ensure resident receives the proper treatment and care of special services. (respiratory care)** 1. Residents with oxygen orders were reviewed for correct flow meter rate. Residents #'s 1, 3, 5: Nasal cannulas were changed. Resident #1: Oxygen flow meter set at 3L/min. as ordered. *By Licensed Nurse* 2. All other residents with oxygen orders were reviewed. All other residents were receiving correct liters of oxygen/min as ordered. *By Licensed Nurse*	4/28/2012 4/28/2012

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F 328	Continued From page 16 review, the facility failed to ensure that five of five residents (1, 2, 3, 4, nd 5) who used oxygen therapy received the necessary care and treatment in a total sample of 10 residents. The nasal cannulas (tube with two prongs placed into the nares to deliver oxygen) of these residents were not labeled with a date of when they were last changed or replaced. This deficient practice had the potential to cause infection. In addition, the facility staff failed to post a "No smoking/oxygen in use" sign outside the room of Resident 1 as a precautionary measure in accordance with the facility's policy and procedure and failed to follow the physician's order for oxygen therapy. This had the potential to result in complications from receiving more oxygen than the body requires. Findings: a. A review of the Admission and Discharge Summary of Resident 1 indicated the resident was admitted to the facility on April 20, 2012, with diagnoses that included end stage renal (kidney) disease, congestive heart failure (a condition in which the heart can no longer pump enough blood to the rest of the body), and hypotension (low blood pressure). A review of a physician's order dated April 21, 2012, indicated to administer oxygen at a rate of three liters per min (L/min) via nasal cannula as needed (PRN) for shortness of breath. On April 26, 2012, at 5:10 p.m., during the initial tour observation with the director of nursing (DON), the resident was observed in bed receiving oxygen inhalation at a rate of five L/min	F 328	3. Residents' ordered for oxygen were reviewed. All residents with oxygen in use, nasal cannulas were changed. *By Licensed Nurse*	4/28/2012
			4. In-service provided to licensed nurses for policy and procedure of changing nasal cannulas weekly and monitoring oxygen flow meter rate per MD order. *By DON*	5/9/2012
			Monthly audit for residents with current oxygen order to ensure changing of nasal cannula per policy. *By DSD or DON*	
			Monthly audit for residents with current oxygen orders to ensure correct flow meter rate. *By DSD or DON*	
			Results of audits will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	

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F 328	Continued From page 17 via nasal cannula from an oxygen concentrator. The oxygen tubing was observed with no label or date of when it was last changed. Upon further observation, there was no sign posted to indicate that oxygen was in use. During another observation on April 26, 2012, at 7:40 p.m., the resident was observed in bed awake and oriented, receiving five L/min of oxygen inhalation via nasal cannula from an oxygen concentrator. The oxygen tubing was observed with no date or label of when it was last changed and there was no sign posted to indicate that oxygen was in use. On April 26, 2012, at 7:45 p.m., during an interview, registered nurse (RN) 1 stated she could not find a "No smoking" or "Oxygen in use" sign outside the resident's room. RN 1 stated there should have been a sign posted on the resident's door. Upon further interview, RN 1 stated that she was unaware of when the resident's nasal cannula was last changed because the tubing was not dated or labeled. According to RN 1, nasal cannulas are changed or replaced at least once a week. During an observation on April 27, 2012 at 6 p.m., the resident was observed sitting up in bed receiving oxygen inhalation at a rate of four L/min via nasal cannula. At 7:35 p.m., the resident was observed in bed receiving oxygen inhalation at three and a half L/min via nasal cannula. During an interview with licensed vocational nurse (LVN) 1 on April 27, 2012 at 7:35 p.m., after she reviewed the physician's order for oxygen, she stated that the oxygen should have been set at a	F 328		

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F 328	Continued From page 18 rate of three L/min per physician's order. On April 28, 2012 at 11:20 a.m., during an interview with the director of nursing (DON), she stated that nasal cannulas are changed by the night shift nurses every week, but could not specify the exact day of the week they are changed. The DON was unable to provide documented evidence that the residents' nasal cannulas were changed on a weekly basis. The facility's policy and procedure titled "Oxygen Administration" dated March 2004, indicated for safe oxygen administration, review the physician's orders or facility protocol for oxygen administration and display "No Smoking" or "Oxygen in Use" signs prominently in areas where oxygen is stored or in use. b. On April 28, 2012 at 5:20 p.m., during the initial tour observation with the director of nursing (DON), Resident 2 was observed in bed receiving oxygen inhalation at a rate of two and a half liters per minute (L/min) via nasal cannula from an oxygen concentrator. The oxygen tubing was observed with no label or date of when it was last changed. A review of the Admission and Discharge Summary of Resident 2 indicated the resident was admitted to the facility on September 19, 2011, with diagnoses that included chronic airway obstruction, dementia (loss of mental abilities), and hypertension (high blood pressure). A review of a physician's order dated September 19, 2011 indicated to administer oxygen at a rate of two to five L/min via nasal cannula or mask	F 328		

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F 328	Continued From page 19 continuously for comfort and for a diagnosis of chronic airway obstruction. A care plan dated September 19, 2012, indicate the resident was at risk for respiratory distress related to a diagnosis of chronic obstructive pulmonary (lung) disease as manifested by wheezing/crackles (abnormal lung sounds). The care plan goal indicated the resident would have no signs and symptoms (s/s) of respiratory distress daily for 90 days. The listed nursing interventions included to provide oxygen inhalation as ordered and administer medications as ordered. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated March 5, 2012, indicated the resident had short and long-term memory problems, was severely impaired in his cognitive skills for daily decision-making, sometimes understood others and sometimes made himself understood, and required total assistance with all activities of daily living. According to the MDS, the resident was on oxygen therapy during the last 14 days. On April 26, 2012 at 7:50 p.m., during an interview, registered nurse (RN) 1 went inside the resident's room with the surveyor to check the resident's oxygen set. RN 1 stated that she was unaware of when the resident's nasal cannula was last changed because the tubing was not dated or labeled. RN 1 stated that nasal cannulas are changed or replaced at least once a week. According to RN 1, the nasal cannula should have been labeled with a date of when it was last changed.	F 328		

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F 328	Continued From page 20 On April 28, 2012, at 11:20 a.m., during an interview with the director of nursing (DON), she stated that nasal cannulas are changed by the night shift nurses every week, but could not specify the exact day of the week they are changed. The DON was unable to provide documented evidence that the residents' nasal cannulas were changed on a weekly basis. c. On April 26, 2012 at 5:35 p.m., during the initial tour observation with the director of nursing (DON), Resident 3 was observed in bed receiving oxygen inhalation at a rate of two liters per minute (L/min) via nasal cannula from an oxygen concentrator. The oxygen tubing was observed with no label or date of when it was last changed. A review of the resident's Admission and Discharge Summary indicated the resident was admitted to the facility on February 25, 2012, with diagnoses that included dementia (loss of mental ability), chronic kidney disease, chronic airway obstruction, and dysphagia (difficulty swallowing with gastrostomy tube (GT- a tube inserted through the abdomen that delivers nutrition or medication directly to the stomach. A review of a physician's order dated February 25, 2012, indicated to administer oxygen at a rate of two L/min via nasal cannula as needed (PRN) for shortness of breath. The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated March 8, 2012 indicated the resident had short and long-term memory problems, was severely impaired in his cognitive skills for daily decision-making, rarely/never understood others	F 328		

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F 328	Continued From page 21	F 328		

and rarely/never made himself understood, and required total assistance from the staff with all activities of daily living. The MDS did not indicate that the resident was on oxygen therapy.

On April 26, 2012, at 7:50 p.m., during an interview with registered nurse 1 (RN 1), she stated that nasal cannulas are changed or replaced at least once a week. According to RN 1, the nasal cannula should be labeled with a date of when it was last changed.

On April 28, 2012, at 11:20 a.m., during an interview with the director of nursing (DON), she stated that nasal cannulas are changed by the night shift nurses every week, but could not specify the exact day of the week they are changed. The DON was unable to provide documented evidence that the residents ' nasal cannulas were changed on a weekly basis.

d. On April 28, 2012 at 7:45 p.m., Resident 4's oxygen tubing was observed next to the bedside. The tubing was attached to a mask and placed inside a privacy bag hanging from the bed. The tubing was not dated. In another observation on the same day at 7:50 p.m., Resident 5 was observed in his room sitting in a wheelchair. The resident had on a nasal cannula (a piece of tubing inserted through a residents nostrils used to administer oxygen) which was infusing at a rate of 2.5 liters (L) of oxygen per minute. The nasal cannula tubing had a small piece of clear tape attached to it. It was unclear what was written on the tape.

Review of an admission "Face Sheet", indicated

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F 328	Continued From page 22 Resident 4 was admitted to the facility on January 26, 2012, and was re-admitted on February 8, 2012. The resident's diagnoses included brain damage and pneumonia (an inflammation of the lungs caused by an infection). A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated February 23, 2012, indicated the resident cognitive skills for daily decision making are severely impaired. The resident is totally dependant on staff for transfers, dressing, and personal hygiene. Review of a care plan titled, "Cardiac/Circulatory Diseases", dated March 10, 2012, indicated the resident was at risk for headaches related to brain damage. The care plan interventions included to administer oxygen as needed for shortness of breath. Review of a physician's order dated March 16, 2012, indicated to administer oxygen at a rate of 2 L per minute as needed for shortness of breath. e. A review of the admission, "Face Sheet", indicated Resident 5 was admitted to the facility on December 8, 2009 and was re-admitted on March 27,2011. The resident's diagnoses included chronic airway obstruction and pulmonary congestion (a respiratory condition that occurs when an irregular amount of fluid fills the air sacs of the lungs, causing shortness of breath), and congestive heart failure (the inability of the heart to pump enough blood to meet the body's needs). A Minimum Data Set (MDS), a standardized	F 328		

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F 328	Continued From page 23 assessment and care screening tool, dated April 11, 2012, indicated the resident was able to make himself understood and able to understand others. The resident required limited assistance with transfers, dressing, and personal hygiene. Review of a physician's order dated June 10, 2011, indicated oxygen at a rate of 2.5 L per minute was to be administered via nasal cannula every shift for congestive heart failure. In an interview on April 26, 2012 at 7:50 p.m., registered nurse (RN) 1 stated the oxygen tubing is supposed to be changed every week. When asked how the nurses are able to track when the tubing is changed, the nurse was unable to answer. When asked if the nurses keep a log or some type of documentation of when the oxygen tubing is being changed the nurse was unable to answer. The nurse then stated, "I try to do the tubing change every Sunday." In an interview on April 26, 2012 at 11:15 a.m., the director of nursing (DON) was asked how the facility ensures the oxygen tubing is being changed weekly. The DON stated the facility does not date the oxygen tubing. The DON also stated "The evening nurses take it upon themselves to change the nasal cannula." When asked if there was any documentation that showed the nasal cannula was being changed on a weekly basis the DON stated "There is no evidence that proves the nasal cannula is being changed". Review of the facility policy titled "Oxygen Administration" revised March 2004, indicated after completing oxygen set up or adjustment the following information should be recorded: The	F 328		

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	555832	A. BUILDING _____ B. WING _____	04/26/2012

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CLARA BALDWIN STOCKER HOME	627 S VALINDA AVENUE WEST COVINA, CA 91790

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F 328	Continued From page 24 date and time that the procedure was performed.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that gradual dose reductions were attempted for two of six sampled residents (7 and 10) who received psychotherapeutic drugs in a sample of 10 residents. This had the potential to result in	F 329	Facility will ensure that each resident's drug regimen is free from unnecessary drugs including excessive doses, duplicate therapy; 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. 1. Resident #7: MD was contacted and psychiatrist. Psychiatrist reduced Depakote and Cymbalta dose and behavior manifestations received for use of Depakote. *By Licensed Nurse* 2. Resident #10: MD was contacted and ordered a dose reduction of Remeron. *By Licensed Nurse* 3. Pharmacist Consultant conducted a drug regimen review on all residents. *By Pharmacist Consultant* 4. In-service provided to licensed nurses for unnecessary drugs. *By DON*	5/1/2012 5/2/2012 5/9/2012 5/9/2012

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F 329	Continued From page 25 significant adverse consequences from possible excessive doses, inadequate monitoring, and prolonged use of psychotherapeutic medications. Findings: a. During the initial tour observation on April 26, 2012 at 5:40 p.m., Resident 7 was observed in her room, sitting in a wheelchair while watching television. The resident was pleasant in talking with the surveyor. A review of the Admission and Discharge Summary of Resident 7 indicated the resident was admitted to the facility on August 23, 2011, with diagnoses that included altered mental status, depressive disorder, and dementia (loss of mental abilities). A review of a physician's order dated August 23, 2011, indicated to administer Cymbalta (antidepressant) 30 milligrams (mg) every night at bedtime for depressive disorder manifested by unpleasant mood and to monitor for episodes of unpleasant mood every shift. There was another physician's order dated August 25, 2011, indicating to administer Depakote (mood stabilizer) 125 mg every twelve hours for dementia. However, the physician's order did not indicate the target symptom and the specific behavior manifestation to be monitored for the use of the Depakote. A care plan dated August 23, 2011, indicated that the resident had problems with her mood state as manifested by episodes of unpleasant mood. The care plan goal indicated the resident would express positive feelings about care and	F 329	Monthly audit will be conducted by Pharmacist Consultant for unnecessary drugs. Audit will be reviewed. *By Pharmacist Consultant and DON* Results of audit will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	

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	555832	A. BUILDING _____ B. WING _____	04/28/2012

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F 329	Continued From page 26	F 329		

assistance of staff and respond in a positive manner to interactions with staff, family, and others by 90 days. The listed nursing interventions included to administer Cymbalta as ordered. Another care plan dated August 25, 2011, indicated that the resident had behavioral symptoms manifested by socially inappropriate or disruptive behavior related to dementia and altered level of consciousness. The care plan goal indicated the resident would interact peacefully in social situations and converse with others without swearing, threatening, or screaming by 90 days. The listed nursing interventions included to monitor behaviors and administer Depakote as ordered. Both care plans did not indicate when to perform a gradual dose reduction.

The Minimum Data Set (MDS), a standardized assessment and care planning tool, dated November 6, 2011, indicated the resident was able to complete the brief interview for mental status, able to understand others and make herself understood, and required limited assistance with most activities of daily living. The MDS indicated the resident did not exhibit mood or behavioral problems, but received antidepressant and antipsychotic medications during the last seven days.

A review of the Psychoactive Summary Sheet for Cymbalta revealed the resident only exhibited one to three episodes of unpleasant mood in November 2011 and December 2011. The summary sheet disclosed that the resident did not exhibit further behavior episodes from January 2012 through April 28, 2012. In addition, a review of the Psychoactive Summary Sheet for

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F 329	Continued From page 27 Depakote did not indicate a target symptom or what specific behavior manifestation to monitor for the use of the Depakote. According to a Note to Attending Physician/Prescriber dated February 24, 2012, the facility's consultant pharmacist recommended to attempt a gradual dose reduction for Cymbalta and Depakote. A review of the physician/prescriber response indicated the physician disagreed with the recommendation and to continue with previous order. The physician put a check mark next to a statement indicating "clinically contraindicated because any additional gradual dose reduction would impair the resident's function." However, there was no documented evidence of a past failed attempt to reduce the dose of Cymbalta and Depakote since it was ordered in August 2011. During an interview with the resident on April 26, 2012 at 5:50 p.m., she stated she likes living in the facility and is satisfied with the care of the staff. The resident was pleasant during the interview and denied feeling depressed. On April 28, 2012 at 11 a.m., during an interview with registered nurse (RN) 1, she reviewed the clinical record and was unable to find a documentation of what specific symptom or behavior manifestation is being treated and monitored for the use of the Depakote. RN 1 stated she will clarify the order with the physician. During an interview with the director of nursing (DON) on April 28, 2012 at 11:20 p.m., after reviewing the resident's clinical record, she stated there was no gradual dose reduction attempted	F 329		

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F 329	Continued From page 28 for the Cymbalta and the Depakote. The DON was unable to find a documented evidence of a reason why a gradual dose reduction would be clinically contraindicated. The facility's policy and procedure titled "Unnecessary Medications" dated January 2009, indicated each resident's medication regimen must be free from unnecessary drugs. The consultant pharmacist, in cooperation with the interdisciplinary team, will identify medications that may be considered "unnecessary." The attending physician will be notified for clarification or alteration of the medication order. b. Review of an "Admission and Discharge Summary", indicated Resident 10 was admitted to the facility on October 4, 2010. The resident's diagnoses included depression. A Minimum Data Set (MDS), a standardized assessment and care screening tool, dated October 17, 2011, indicated the resident was able to make herself understood and able to understand others. The resident required limited assistance with transfers, dressing, and personal hygiene. Review of a physician's order dated January 24, 2011, indicated Remeron (an anti-depressant) 30 milligrams (mg) to be given by mouth at hour of sleep for depression. Review of the pharmacist's form titled, "Note to Attending Physician/Prescriber", dated July 19, 2011, indicated the resident has been on Remeron 30 mg to be administered at hour of sleep and a gradual dose reduction is due if medically warranted. The note also indicated that	F 329		

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F 329	Continued From page 29 according to the psychiatry notes on May 2011, the resident was stable. The pharmacy indicated a gradual dose reduction must be attempted on psychoactive medications unless clinically contraindicated. According to the pharmacist there was no documentation from the residents physician indicating a gradual dose reduction was clinically contraindicated. Review of the form, "Psychoactive and Sedative/Hypnotic Assessment Tool", dated January 24, 2011 indicated the resident was receiving Remeron for depression manifested by crying and self reports of feeling depressed. The form indicated the order for the medication was initiated in the nursing center. The same form had an entry dated July 19, 2011, which indicated no dose reduction per medical doctor (MD). Another entry dated July 30, 2011, indicated no gradual dose reduction per psychiatrist. Review of a "Psychiatric Progress Note", dated December 24, 2011, indicated the resident was alert, calm, and cooperative. According to the note the staff had reported the resident was eating good, sleeping good, and had no recent behavioral problems. The psychiatrist's assessment indicated the resident was stable and the plan was to monitor and continue current regimen. In an interview on April 28, 2012 at 9:50 a.m., registered nurse (RN) 2 was asked if the resident had many episodes of depression. The RN stated in the past the resident had episodes of crying and would at times state she felt depressed. According to the RN the resident had fewer episodes of crying than in the past.	F 329		

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F 329	Continued From page 30 In an interview on April 26, 2012 at 11:25 a.m., the director of nursing (DON) stated there had been no attempt at a gradual dose reduction for the Remeron prescribed to the resident since January 2011. When asked if there was any documentation from the physician indicating a gradual dose reduction was clinically contraindicated the DON stated she could not find any documentation from the physician. The DON also stated, "We understand, there has to be a GDR." This is a repeat deficiency from the last Recertification survey dated January 13, 2011.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and protect food under sanitary conditions regarding one malfunctioning refrigeration unit and one unlabeled bulk food container. Findings:	F 371	The facility will store food and protect food under sanitary condition. 1. The light bulbs in the refrigeration units and in the freezer were replaced. *By Maintenance Staff* 4/26/2012 2. A label with name and date was placed on the 5-gallon bulk food container. *By Dietary Staff* 4/26/2012 All light bulbs in the dietary dept. were checked. All containers in the pantry were checked for name and date labels. *By Dietary Staff* 4/26/2012	

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F 371	Continued From page 31 On April 26, 2012 between 5:05 p.m. and 6:15 p.m., during the kitchen observation, the evaluator observed the following: 1. One of five refrigeration units had burnt out light bulbs inside. Closer observation revealed that the McCall freezer had two of two burnt out light bulbs. 2. One of four bulk food containers was not labeled nor dated. The 5-gallon bulk food container was filled with a dry white powdery food, possibly dry milk. Closer observation revealed the other bulk food containers were identified with the name of the food and dated when the food was placed inside the containers. On April 26, 2012, at 7:05 p.m., the evaluator conducted an interview with the administrator. During this interview, the refrigeration units with burnt out light bulbs and the bulk food containers with no label or date, were brought to her attention. The administrator stated these items would be corrected, as soon possible.	F 371	Light bulbs will be monitored. All containers in pantry will be monitored for name and date labels. *By dietary Staff* *By Safety Committee Surveys* The results of the monitoring will be reviewed to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	**Facility will ensure that drugs and biologicals used in the facility be labeled in accordance with current accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.**	

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F 431	Continued From page 32 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to remove expired medications from the medication rooms and lock and replace an opened emergency kit (E-kit). These failures had the potential of putting residents at risk should they be administered expired medications or in the event that the residents should need medications from the E-kit, that were not yet replaced. An inspection of the medication room located at Station 2 on April 26, 2012 at 4:55 p.m., revealed	F 431	**Facility will store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.** **Facility will provide for storage of controlled drugs listed in scheduled II of the comprehensive drug and abuse act of 1976 and other drugs subject to abuse in a single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.** 1. Flu vaccine and expired medication was removed and placed in disposition cabinet. E-Kit was re-sealed and replaced with a replacement E-Kit. *By DON*	4/26/2012
			2. All medications were checked for expiration dates. No expired medications were found. Remaining E-Kits were sealed. *By DON*	4/27/2012
			3. In-service given to licensed nurses to monitor expiration dates and procedure on E-Kit replacement. *By DON*	5/9/2012

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F 431	Continued From page 33 the following: 1. A multi-dose vial of Novolin 70/30 insulin with an open date of February 5, 2012 (81 days ago). 2. An unlocked E-Kit missing a vial of NPH insulin. Review of the form titled, "Drug Return Disposition Log", dated April 22, 2012, indicated: 1. Remove Dose 2. Fill out slip for each dose used 3. Place top copy in E-kit: Duplicate copy in E-kit log book According to the form Insulin was removed from the E-kit on April 22, 2012. There was no name on the form as to who the insulin was used for. During an interview on April 26, 2012 at 6 p.m., registered nurse (RN) 1 acknowledged the vial of Insulin was expired and the facility had failed to remove it from the refrigerator where the medications are stored. According to the RN insulin is only good for 28 days once opened. When asked why the E-kit was not locked the RN stated it had been opened and a vial of insulin had been removed. The RN could not remember when the E-kit had been opened. The nurse was asked what the facility's procedure is for E-kits that have been opened. The nurse stated a log is kept indicating when medications are removed and the type of medication that is removed. The nurse also stated once having opened the E-kit a copy of the dose slip should be placed in the E-kit (the E-kit did not have a dose slip indicating a medication had been removed) the E-kit should be locked with a zip tie (included with every E-kit) and the	F 431	Monthly audits will be conducted by DSD or DON. Quarterly audits will be conducted by Pharmacist Consultant. *By DSD or DON* *By Pharmacist Consultant* Results of audit will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	

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F 431	Continued From page 34 pharmacy should be notified so that the kit can be replaced. When asked if the pharmacy had been notified about the opened E-kit the nurse stated "Not yet, I was going to do it." In an interview on April 28, 2012 at 11:25 a.m., the director of nursing (DON) stated when an E-kit is opened and a medication is removed a slip is filled out (indicating the medication that is used) and placed inside the kit. The pharmacy is then notified that the E-kit has been opened. The DON stated the E-kit should be replaced within 72 hours. Review of the facility policy titled, "Emergency Kit Replacements", dated January 2008, indicated emergency kits are to be replaced within 72 hours of the time opened and the pharmacy should be notified whenever the emergency kit is used. Review of another policy titled, "Interpretation of Labeled Expiration Dates", dated January 2009, indicated drugs shall not be kept in stock after the expiration date on the label. b. On April 26, 2012 at 4:55 p.m., during an inspection of the medication room in Station 1 with the director of nursing (DON), a bottle of Vancomycin 125 milligrams (mg)/5 milliliters (ml) with an expiration date of April 10, 2012 and a multidose vial of Flulaval (flu vaccine)with an open date of March 12, 2012, were obaerved in the medication refrigerator. During an interview with the DON on April 26, 2012, at 5 p.m., she stated that the bottle of the expired Vancomycin belonged to a resident who was no longer in the facility and the multidose vial of Flulaval was good until the expiration date indicated on the label (June 2012). The DON stated she has not had the time to discard the	F 431		

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F 431	Continued From page 35 expired medication. According to the Centers for Disease Control and Prevention (2011), under Vaccine Storage and Handling Guide, a multidose vial that is normal in appearance, stored and handled properly can be used through the expiration date printed on the vial unless otherwise stated in the manufacturer's product information. However, once entered, a multidose vial of Afluria or FluLaval should be discarded after 28 days. The facility's policy and procedure titled "Interpretation of Labeled Expiration Dates" dated January 2009, indicated drugs shall not be kept in stock after the expiration date on the label.	F 431		
F 485 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for the residents and staff, regarding drain lines that did not have air gaps for one kitchen sink and the ice machine. Findings: On April 26, 2012 at 5:45 p.m., during the kitchen observation, the evaluator observed that the three compartment sink had a drain line that entered	F 485	**The facility drain lines will have air gaps for kitchen drain and the ice machine drain.** 1. The drain lines with air gaps were repaired. *By Maintenance Staff* — 4/26/2012 2. All floor drains were checked to ensure they have air gaps. *By Maintenance Staff* — 4/26/2012 Inspections of the drain lines will be done on an ongoing basis. *By Maintenance Staff* Results of inspections will be monitored to ensure correction is achieved and sustained on a quarterly basis. *By Quality Assurance Committee*	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555832	A. BUILDING _____ B. WING _____	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA BALDWIN STOCKER HOME	527 S VALINDA AVENUE WEST COVINA, CA 91790

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F 465	Continued From page 36 directly into a floor sink. (A floor sink is a liquid waste receptacle, which is similar to a one square-foot sink located at the floor level that is connected to a sewer system.) Closer observation revealed that this drain line did not have an air gap. (An air gap is the minimum vertical distance from the lowest point of the indirect drain line with a separation above the flood level rim of the floor sink/receptacle. The air gap prevents the possibility of sewage backing up into the equipment.) On April 26, 2012 at 7:20 p.m., during a general observation, the evaluator observed an ice machine was inside a utility room, behind the rear nursing station. Closer observation revealed that the ice machine's drain line entered directly into a floor receptacle, directly under the ice machine. This drain line did not have an air gap. On April 26, 2012 at 7:50 p.m., the evaluator conducted an interview with the maintenance staff regarding the two drain lines which did not have air gaps. During this interview, the evaluator mentioned that if there were a backup sewage, the sewage would enter the drain lines, and contaminate the three compartment sink and the ice machine. The maintenance staff stated these two drain lines would be corrected, immediately.	F 465		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.	F 518	Facility will train all new staff in emergency procedures when they begin employment and periodically review the procedures with existing staff. 1. In-service given to staff regarding emergency procedures. *By DSD*	5/9/2012

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	555832	A. BUILDING _____ B. WING _____	04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA BALDWIN STOCKER HOME	527 S VALINDA AVENUE WEST COVINA, CA 91790

(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 518	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two of eight facility staff were aware of the facility's disaster and emergency preparedness procedures for various disasters. This had the potential to result in a delay in the staffs response time during a disaster. Findings: On April 27, 2012 at 6 p.m., the surveyor reviewed the facility's disaster manual. The manual indicated that the facility's fire code was "Dr. Firestone" and any other disaster's code was "Code Triage." In addition, according to the manual, the staff are to evacuate the residents outside of the facility (yard or parking lot) in case of an earthquake. Between April 27, 2012, and April 28, 2012, eight separate interviews were conducted with eight different staff from all three shifts. During an interview with licensed vocational nurse (LVN) 1 from the 2 p.m. to 10 p.m. shift on April 27, 2012, at 7 p.m., she could not recall the facility's fire code. When asked about the facility's earthquake evacuation plan, LVN 1 stated she would evacuate the residents in the activity room or in the hallways in case of an earthquake. On April 28, 2012, at 7 a.m., during an interview with registered nurse (RN) 4 from 10 p.m. to 6 a.m. shift, she could not recall the facility's code for other disasters.	F 518	Monthly and quarterly audit and review of emergency procedures for staff to ensure correction is achieved and sustained. *By Safety Committee*	

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F 518	Continued From page 38 During an interview with the director of staff developer (DSD) on April 28, 2012 at 9:15 a.m., she stated that she provides disaster and emergency preparedness in-service at least twice a year. The DSD stated she would in-service the staff on the facility's disaster and emergency preparedness plan as soon as possible.	F 518		