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 _____ CALIFORNIA DEPARTMENT OF PUBLIC HEALTH	C 07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR THE RIDGE REHABILITATION CENTER	350 IRIS DRIVE SALINAS, CA 93906 JUL 27 2015

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey regarding investigation of a complaint conducted on 7/3/15 through 7/13/15. For Complaint CA00448231, regarding Quality of Care/Treatment, Federal Deficiencies were identified (see F279 and F425). Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 34432, 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] **Signature**	
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	F 279	**F-279** **CORRECTIVE ACTION:** On 7/22/2015, Medical Records audited careplans for all residents with diagnosis of insomnia. Admissions Nurse updated care plans to reflect altered sleeping pattern on 7/22/2015. **IDENTIFICATION:** Any residents with insomnia may be affected. **MEASURES TO PREVENT REOCCURANCE:** Admission Nurse will initiate preliminary care plans and entries for each resident's individual needs. MDS nurse will update Care Plan along with the MDS as applicable. IDT members and charge nurses will update careplans as needed. DON in-serviced MDS, Admission nurse, Charge Nurses on the	7/22/15 7/22/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 7/24/15

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.

7/27/15 Spoke to adm 3:45pm Accepted POC [redacted]

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F 279	Continued From page 1 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and revise a comprehensive care plan for insomnia (trouble sleeping) for one of three sampled residents (1). This failure had the potential to result in the resident not receiving care and services. Findings: During an interview with registered nurse A (RN A) on 7/6/15 at 10 a.m., he stated there should have been a written care plan to address Resident 1's sleeping difficulty and to reflect the interventions employed to resolve the problem. During an interview with the director of nursing (DON) on 7/6/15 at 3:30 p.m., she stated there should be one, but she was not able to find a care plan for insomnia in Resident 1's clinical record. The facility's 11/2012 policy "Care Planning" indicated a comprehensive care plan should be developed for problems and concerns experienced by the resident including medically defined conditions and concerns identified by the resident.	F 279	subject of completing comprehensive care planning on 7/22/2015 and 7/23/15. **MONITORING AND INCORPORATION INTO THE QA&A SYSTEM:** CQI plan was developed for care planning: medical records will audit every admission and every assessment. Number of missing care plans will be brought to DON for the monthly QA&A by medical records for further discussion and resolution. **COMPLETION:** 7/23/2015 by Director of Nursing.	7/22/15 7/23/15 7/23/15
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	F 425	**F-425** **CORRECTIVE ACTION:** 1. Pharmacy provided CQI on 7/23/15. DON/DSD in serviced licensed staff on the importance of obtaining and administering correct medications via correct delivery methods and dosing methods form, 5 rights of medication	7/23/15

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F 425	Continued From page 2 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 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 a medication as ordered by a physician for two of three (1, 2) sampled residents. For Resident 1, the facility failed to provide a respiratory medication (medication for lungs, to assist with breathing) in the correct dosage and delivery method (how the medication enters the body) and resulted in Resident 1 receiving a higher dose of the medication than ordered. For Resident 1 and Resident 2, the facility failed to have respiratory medications available on a daily basis and resulted in missed doses of medication. These failures had the potential to result in increased or adverse effects from taking a higher than ordered dose of medication and decreased effectiveness from missing doses of medication. Findings: 1. Resident 1's clinical record on 7/3/15 indicated a physician's order, dated 2/16/15, for Formoterol Fumarate Capsule (a medication for breathing	F 425	administration and 3 checks of medication administration on 7/22/2015and 7/23/2015. 2. Inserviced licensed nurses on timely ordering and medication administration on 7/22/2015 & 7/23/2015. **IDENTIFICATION**: All residents may be affected. **MEASURES TO PREVENT REOCCURANCE**: 1. DON will perform spot checking to confirm that correct dosages/routes are being delivered by pharmacy by comparing 7 manifests per week with orders in MAR starting on 7/23/2015 for 2 months. DON to audit medications not being administered on a daily basis to follow up with pharmacy (7/13/2015 and ongoing). Pharmacy Nurse Consultant shall continue with audits per pharmacy regulations. Charge nurses to notify DON of any issues regarding the delivery of medication (in-service 7/22/2015 and 7/23/2015).	7/22/15 7/23/15 7/22/15 7/23/15 7/23/15 7/13/15 7/22/15 7/23/15

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F 425	Continued From page 3 problems) one capsule inhale orally (the capsule is placed in a chamber of an inhaler and releases a powder from the capsule that is inhaled) two times a day related to chronic airway obstruction (lung disease). During an interview and record review with registered nurse A (RN A) on 7/6/15 at 11:20 a.m., he stated Resident 1 received Formoterol twice a day inhaled through a nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) and not through an inhaler. RN A stated the medication Formoterol was not available on 2/17/15, 2/25/15, and 3/12/15, documented in the "Nursing Progress Notes" and the "Medication Administration Record (MAR). A review of the pharmacy document "Transaction History" on 7/16/15 at 1 p.m., indicated a seven day supply of Resident 1's Perforomist (Formoterol) 20 micrograms (mcg.) two milliliter (ml.) vial was received on 2/16/15, 2/25/15, 3/5/15, 3/10/15, 3/14/15, and 3/23/15. During an interview and pharmacy document review with the director of nursing (DON) on 7/6/15 at 1 p.m., she verified Resident 1 received 20 micrograms (mcg.) two milliliter (ml.) vial administered via nebulizer instead of Formoterol Capsule as indicated in the physician order. The DON confirmed the pharmacy documents indicated Resident 1 only received a six week supply of Formoterol during her six week, five day stay at the facility. The resident received 42 doses but should have received 47 doses during her stay. During a telephone interview with the registered	F 425	2. DSD/DON inserviced all inserviced staff on the importance of obtaining and administering correct medication via correct delivery method and correct dose form, inserviced nurses on five rights of medication of administration and three checks of medication administration on 7/22/2015 and 7/23/2015.	7/22/15 7/23/15

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F 425	Continued From page 4 doctor of pharmacy B (RPharmD B) on 7/6/15, at 1:35 p.m., he stated the pharmacy dispensed Perforomist (Formoterol) 20 mcg/2 ml 14 vials or seven day supply on 2/16/15, 2/25/15 (14 doses delivered over two days on 3/5/15 and 3/6/15), 3/10/15, 3/14/15, and 3/23/15. RPharmD B stated the pharmacy dispensed an incorrect dose and delivery method of Formoterol for Resident 1. During a telephone interview with RPharmD C on 3/6/15, at 2 p.m., he stated the pharmacy dispensed an incorrect dose and delivery method of Formoterol for Resident 1. RPharmD C stated the dispensing record indicated the nurses were administering Formoterol in an incorrect dose and delivery method during Resident 1's stay at the facility. Review of Lexicomp Online (www.lexi-comp.com, a service for clinicians providing access to three drug information resources within a single interface) indicated Formoterol Fumarate Capsule delivers twelve micrograms of Formoterol with each use while Formoterol two ml. vials of liquid for use in a nebulizer delivers 20 micrograms of Formoterol with each use. 2. Resident 2's clinical record on 7/6/15 indicated a physician's order, dated 1/5/15, for Advair Diskus Aerosol Powder Breath Activated 500-50 mcg/dose (Fluticasone-Salmeterol, a medication for breathing) one dose inhaled two times per day. The 4/15 MAR and "Nurses Progress Notes", also dated 4/15, indicated the Advair was not available for administration on 4/1/15 and on 4/19/15. During an interview and pharmacy document review with the DON on 7/6/15 at 4 p.m., she	F 425	**MONITORING AND INCORPORATION INTO THE QA&A SYSTEM:** CQI plan was developed for pharmacy ordering, five rights of medication administration and triple check by Director of nursing. Medical Records & Director of Nursing to bring CQI and further concerns, if any, to QA&A monthly and quarterly meetings. **COMPLETION:** 7/23/2015 by Director of Nursing.	7/23/15

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F 425	Continued From page 5 stated the medication "Transaction History" indicated Resident 2 received a one week supply of Advair on 2/17/15, 4/3/25, 4/11/15, and a thirty day supply of Advair on 4/30/15. The DON confirmed there was a gap in delivery records of Resident 2's Advair between 2/17/15 and 4/3/15. The DON stated Resident 2 did not receive Advair from any other pharmacy during that time. During an interview with RPharmD D on 7/6/15 at 4 p.m., he confirmed the pharmacy delivered Advair for Resident 2 on the above dates and there was no documentation of Resident 2's Advair dispensed between 2/17/15 and 4/3/15. The facility's 2008 policy "Medication Ordering and Receiving From Pharmacy" indicated resident medications are ordered and dispensed on a timely basis to assure an adequate supply is on hand for medication administration.	F 425		