STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056161	A. BUILDING _____ B. WING _____	08/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN CREST REHABILITATION CENTER	909 LUCILE AVE. LOS ANGELES, CA 90026

(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 Licensing and Recertification Survey. Representing the Department of Public Health: [redacted] REHS. HFE-I [redacted] RN. HFEN [redacted] REHS, HFE-I Total Population: 58 Sample Size: 15 Highest S/S= F	F 000	Poc accepted Sep 10/2012 [redacted]	
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 observation, interview and record review, the facility failed to ensure the residents who was received Bumex (1) and Lasix (diuretic medications that helps you make more urine and to lose salt and excess water from your body) for edema management and congestive heart failure (CHF) would be consistently monitored for edema to ensure effectiveness of medication for three	F 309		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Gwendolyn Graham | DON | 9/6/12

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 309	Continued From page 1 out of 15 sample residents (1,7,9). Findings: a. On August 16, 2012, at 6:05 p.m., Resident 1 was observed in bed. It was noted the resident had swollen both arms up to elbows and both legs from toes to the knees. The Registered Nurse 1 (RN 1) was asked to assess the resident's edema. RN 1 said the resident had pitting edema +2. At the same time, during a conversation with the resident she said she always has her arms swollen. According to the admission record, Resident 1 was admitted to the facility on July 26, 2012, with diagnoses that included congestive heart failure, hypertension and atrial fibrillation. The Minimum Data Set assessment dated August 2, 2012, indicated the resident had intact cognitive skills for daily decision making and totally dependent on staff for activities of daily living. According to the physician's progress note obtained from the acute care hospital dated July 25, 2012, the resident had +2 edema to both lower extremities. According to the facility's nursing admission dated July 26, 2012, the resident's edema was not addressed. The resident was receiving Bumex 2 milligram (mg) daily for edema as ordered on July 26, 2012. A review of the resident's clinical record indicated there was no plan of care developed for the	F 309	F – 309: Immediate Action: Residents 1, 7 & 9 were immediately placed each ("Q") shift on documentation to assess edema using scale 0-4 until stable. Residents will be weighted Q week until stable. An in-service was given 8/30/2012 by the Director of Nurses ("DON") to all License Nurses regarding the proper way to assess residents with edema. Identification of other affected residents: All residents identified with edema were assessed. The findings were documented and addressed in the Plan of Care ("POC"). Systematic Changes: Licensed nurses were in-serviced to monitor residents who have been identified with edema. Appropriate precautions will be taken so that residents with documented edema will have the appropriate plan of care and that the MD orders are followed. Quality Assurance: All residents with edema will be audited for appropriateness. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/30/12

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F 309	Continued From page 2 management of edema. During an interview with the Director of Nursing (DON) on August 17, 2012, at 4 p.m., she confirmed there was no plan of care in place for edema. DON said it was expected of licensed nurses to monitor the resident for edema at all time and to document at least once a day about it. DON confirmed that monitoring the resident for the presence of edema was one of the nursing intervention to ensure the effectiveness of diuretic therapy with Bumex. A review of the resident's record revealed there was no documented evidence the license nurses monitored the resident for edema consistently. Also a review of the licensed nurses notes dated August 16, 2012, for 3 p.m. to 11 p.m., shift indicated there was no documentation about RN 1 assessment of the resident's edema +2. b. According to the admission record, Resident 7 was admitted to the facility on January 08, 2012, with diagnoses that included chronic airway obstruction, and congestive heart failure (CHF). According to the Minimum Data Set (MDS) dated March 8, 2012, the resident was assessed as having memory problems, [redacted] and needed total assistance with activities of daily living. The resident had a physician's order dated January 8, 2012, for for Lasix 40 mg tablet via gastrostomy tube (Gt) daily for CHF. A review of the resident's clinical record revealed there was no documentation indicating the	F 309		

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F 309	Continued From page 3 resident was monitored for effectiveness of the Lasix treatment to reduce the edema was continuously assessed and monitored. On August 18, 2012, at 4 p.m., the Director of Staff Developer (DSD) assessed the resident for the edema, the resident had a plus one pitting edema in the lower extremities. She also confirmed that the licensed nurses did not have any documentation indicating that they were monitoring the resident's edema. c. According to the admission record, Resident 9 was admitted to the facility on August 3, 2012, with diagnoses that included diabetic mellitus type II, CHF, and hypertension. According to the Minimum Data Set (MDS) dated August 17, 2012, the resident was assessed as appeared to be [redacted] and requiring limited to extensive assistance with activities of daily living. On August 4, 2012, the resident had a physician's order for Furosemide (Lasix) 40 milligrams (mg) one tablet daily for CHF. There was a care plan dated August 4, 2012, stating the resident is at risk for shortness of breath and edema due to congestive heart failure. The intervention included monitor for edema. On August 18, 2012, at 2:05 p.m., an interview, the Director of Nursing indicated there was no documentation indicating that the licensed nurses were monitoring the resident's edema.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the licensed nurses failed to ensure a resident who had an indwelling urinary catheter was monitored for sedimentation in the urine (6) to prevent the potential for urinary tract infection (UTI) and failed to ensure a resident with an indwelling catheter and who had recurrent UTIs was provided incontinent care in accordance with the facility's policy and procedures related to incontinent care for a resident with an indwelling catheter (2) to prevent the potential for UTI for two out of 15 sample resident (2,6). Findings: a. According to the admission record, Resident 6 was admitted to the facility on May 31, 2011 and June 22, 2011, with diagnoses that included pressure ulcer, gastroesophageal reflux disease and [redacted]. According to the Minimum Data Set (MDS) dated June 5, 2012, the resident was assessed as	F 315		

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F 315	Continued From page 5 having memory problems, requires total assistance with activities of daily living, had an indwelling catheter, was incontinent of bowel. On August 16, 2012, at 6:05 p.m., the resident was observed to be in bed and the urinary catheter bag and tubing had moderate amount of sedimentations, which was confirmed with the director of staff developer. On August 17, 2012, at 8:35 a.m. in an interview with the Director of staff developer, and review of the resident's record she confirmed the resident's was not monitored by the licensed nurses for present of sedimentation in the urine collected in the indwelling catheter which could be a possible indication for urinary tract infection. b. On August 17, 2012, at 10:20 a.m., CNA 1 was observed providing Resident 2 with incontinence care after the resident had a bowel movement. The resident was in bed lying on her left side and an indwelling urinary catheter in place. CNA 1 after exposing the resident, wiped off feces from the resident's Perineal area and removed the soiled disposable incontinent brief. During the procedure CNA 1 to wash the resident's perineum area using wash cloth socked with soap in a wash basin. CNA 1 was holding her left arm above the resident's pubic area and squeezing water from a wash cloth, with her right gloved hand washing the resident's genitals area in a circular motion. CNA 1 repeated the same circular motion when she bathed the resident's perineal area and dry the resident's perineal area with a dry towel. CNA 1 did not follow the facility's policy	F 315	F 315: Immediate Action: Resident 6 was immediately placed on a Q shift monitoring for signs and symptoms of urinary tract infection ("UTI") secondary to the presence of a Foley catheter. The Certified Nursing Assistants ("CNA") involved in providing care to resident 2 were immediately in-serviced by the DSD on how to provide Perineal care to a resident with Foley catheter. Identification of other affected residents: All residents with Foley catheters/ Suprapubic catheters and/or Urostomy were assessed and placed on Q shift monitoring for signs and symptoms of urinary tract infection ("UTI"). Systematic Changes: The Facility Policy & Procedure for Catheter Care was revised and the Licensed nurses were in-serviced to monitor Q shift all residents with Foley catheters/ Suprapubic catheters and/or Urostomy for signs and symptoms of urinary tract infection ("UTI"). On 8/30/2012 the DSD in-serviced all Certified Nursing Assistants ("CNAs") on how to provide Perineal care to residents with Foley catheters.	8/30/12

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F 315	Continued From page 6 procedures related to providing care to a resident with an indwelling catheter while she provided incontinent care to Resident 2. A review of the facility's catheter care protocol indicated CNA 1 had to clean catheter insertion area by removing all debris from catheter at the insertion site and rinsing well with warm water and pat dry with a clean towel. According to the catheter care procedure the perineum needed to be cleaned first due to involuntary bowel movement following with obtaining a clean equipment for catheter care. According to the admission record, the resident was admitted to the facility on January 16, 2012, and re-admitted on February 10, 2012, with diagnoses that included acute kidney failure, urinary retention and severe debility. The MDS assessment dated February 13, 2012, indicated [redacted] an d totally dependent on staff for activities of daily living. The MDS indicated the resident was incontinent of bowel and had an indwelling urinary catheter. The resident was assessed as being at risk for developing UTI. There was a plan of care dated February 13, 2012, for the potential for UTI related to indwelling urinary catheter. One of the approaches was to provide catheter care per protocol. According to the facility's procedure on perineal care CNA 1 had to use a wash cloth or disposable or reusable wipes to wash the	F 315	Quality Assurance: The DON will perform ongoing evaluations for compliance. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	

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F 315	Continued From page 7 resident's perineum and utilize a gloved hand instead of wash cloth. A review of the resident's clinical record revealed the resident had been treated for UTI in April, May and August 2012. On May 18, 2012, according to the laboratory report one of the responsible organism for infection was escherichia coli (bacterium inhabiting the gastrointestinal tracts). During an interview with the Director of Nursing (DON) on August 17, 2012, at 11:20 a.m., she verbalized an agreement that CNA 1 put resident at risk for potentially contracting an UTI from providing with perineum care not in accordance with right procedure.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Registered Dietitian (RD) would conduct nutritional assessments in a timely	F 325		

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F 325	Continued From page 8 manner for residents who had Stage IV pressure sores and gastrostomy tube fed for one out of 15 sample residents (6). Findings: According to the admission record, Resident 6 was admitted to the facility on May 31, 2011 and June 22, 2011, with diagnoses that included pressure ulcer, gastroesophageal reflux disease and [redacted] According to the Minimum Data Set (MDS) dated June 5, 2012, the resident was assessed as having memory problems, requires total assistance with activities of daily living, had an indwelling catheter, was incontinent of bowel and had gastrostomy tube feeding and had one unhealed pressure sore. The resident had a physician's order dated June 23, 2011, for Isosource 1.5 Cal at a rate of 45 milliter/hour (ml/hr) for 22 hours via gastrostomy tube to provide the resident with 990 ml / 1485 Kilocalories (Kcal). There was another physician's order for the resident to have Prostat 64, 30 ml via gastrostomy tube daily as a suppiment. A review of the RD's assessment indicated that on October 20, 2011, December 22, 2011, March 28, 2012, May 30, 2012 and July 3, 2012, the resident was assessed by the RD. On August 17, 2012, at 10 a.m., during an interview with the RD and a review of the resident's record, the resident was not assessed every month as indicated by the RD for her dietary and hydration needs. The RD was in	F 325	F 325: Immediate Action: The Registered Dietician ("RD") immediately assessed resident 6 to ensure that the Plan of Care and the Physician Order for the Gastrostomy Tube ("GT") feeding was appropriate for the resident's needs. Identification of other affected residents: All residents with Gastrostomy Tube ("GT") feeding were assessed by the RD. Appropriate recommendations were completed by the RD. Systematic Changes: All residents with Gastrostomy Tube ("GT") feeding will be evaluated by RD Monthly for appropriateness of Nutritional intake, pertinent lab data and recommendations to ensure, as possible, that all residents maintain acceptable parameters of nutritional status. Quality Assurance: A quality assurance will be conducted every month by the Medical Record Designee ("MR") and monitored by the DON and DSD. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/30/12

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F 325	Continued From page 9 agreement that the resident needed to be assessed by the RD every month due to having a Stage IV pressure sore and gastrostomy tube feeding.	F 325		
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 interview and record review the facility failed to ensure a resident on a long-term administration of Ferrous Sulfate (iron) would be	F 329		

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F 329	Continued From page 10 monitored to prevent the potential for adverse effects and complications associated with a long-term use of iron for one out of 15 sample residents (5). Findings: According to the admission record, Resident 5 was admitted to the facility on July 12, 2012, with diagnoses that included anemia, hypertension, hypothyroidism and congestive heart failure. The Minimum Data Set (MDS) assessment dated July 25, 2012, indicated the resident was [redacted] and needed extensive assistance in the activities of daily living. The resident had a physician's order dated July 12, 2012, for Ferrous Sulfate 325 mg twice a day for anemia. A review of the Medication Administration Record (MAR) from July 12, 2012, to August 17, 2012, indicated the resident was administered Ferrous Sulfate 325 mg twice a day as ordered. There was a pharmacist's recommendation dated July 27, 2012, addressed to the resident's physician, to monitor iron level to determine if the resident's iron stores are normal. There was the resident's physician's documented agreement with the pharmacist recommendations, and it was referred to the physician's orders. However, a review of the resident's clinical record indicated there was no documented evidence there was a physician's order for iron level test. There was no documented evidence that indicated the resident had been monitored for potential iron accumulation in a body, and there	F 329	F 329: Immediate Action: The License Nurses immediately notified the MD of his agreement to obtain an iron level for resident 5, and obtained a physician order for Iron level to be done the next morning. Identification of other affected residents: All residents on iron supplement were identified and it was confirmed that an iron level was available for their MDs. Systematic Changes: The Pharmacy consultant will review all residents on iron supplements monthly and will provide appropriate recommendations to ensure that the residents' iron levels are accurate and that the residents' MDs are aware. Quality Assurance: A quality assurance will be conducted every month by the treatment nurse and will be monitored by the DON and the DSD. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/18/12

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F 329	Continued From page 11 was no documented justification for the use of Ferrous Sulfate for twice a day for more than one week without monitoring the potential iron accumulation in the resident's tissue. On August 17, 2012, at 2:10 p.m., during an interview with Director of Nursing, she was not able to provide the documented evidence the resident had been monitored for the potential iron accumulation, or the justification for administering Ferrous Sulfate to the resident without monitoring the potential iron accumulation in the resident's tissue. In addition, there was no documentation of the clinical rationale for when Ferrous Sulfate was ordered for continuous use twice a day for more than one week. According to the State Operational Manual (SOM), clinical rationale should be documented if iron is ordered for a long-term use (greater than two months) or if administered more than once daily (daily for greater than a week), because of side effects and the risk of accumulation of iron in the tissues. Monitoring the baseline serum iron or Ferritin level and periodic complete blood count (CBC) or hematocrit /hemoglobin is needed. Adverse consequences includes constipation, dyspepsia (indigestion, upset stomach) symptoms such as upper abdominal pain, belching, nausea, vomiting, abdominal bloating, abdominal distention), accumulation of iron in tissues that cause multiple complications if given chronically despite normal or high iron stores (SOM, October 2010, Page 390).	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 12 (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 the facility failed to store kitchen utensils, to prepare food, and to maintain the walk-in cooler in a sanitary conditioning. Findings: During the tour of the facility on August 18, 2012, at 10 am, accompanied by the maintenance staff and the administrator, the surveyor observed several boxes of plastic pitchers and cups stored in the cleaning chemical storage closet under exterior the stairway. During the tour of the kitchen at 12 pm, accompanied by registered dietician, the surveyor observed the following: 1. Dietary staff taking of gloves, touching the trash can lid to throw them away, putting on new gloves without washing their hands and proceeded serve the lunch tray line. 2. An accumulation of dust of the fan cover, and mildew on the ceiling and corners inside the walk-in cooler.	F 371	F 371: Immediate Action: 1. The boxes of plastic pitchers were removed immediately from the cleaning chemical storage area. 2. Dietary Staff were immediately in-serviced re: hand washing and sanitation 3. The accumulation of dust of the fan cover, and mildew on the ceiling and corners inside the walking refrigerator were cleaned. Identification of other affected residents: No other accumulations of dust or mildew were identified. Systematic Changes: The maintenance department will conduct weekly rounds in the kitchen to identify any maintenance needs and corrected immediately. Quality Assurance: The maintenance department will conduct weekly rounds in the kitchen to identify any maintenance needs and corrected immediately. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/30/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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	055161	A. BUILDING _____ B. WING _____	08/18/2012

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F 425	Continued From page 13 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 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 observation, interview and record review, Licensed Vocational Nurse 2 (LVN 2) during administration of medication through a gastrostomy tube (GT) failed to ensure crushed solid medication() and liquid medication would be mixed with water and diluted in accordance with facility's policy and procedure and accepted standard of practice before poured into the syringe barrel to be administered to a resident (7) and LVN 1 failed not crush and administer multiple solid medications together that enteric coated Aspirin and administer to a resident (11) for two out of 15 sample residents (7,11).	F 425		

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F 425	Continued From page 14 Findings: a. On August 18, 2012, at 7:50 a.m., LVN 2 was observed administering medication to Resident 11 through GT. LVN 2 was observed preparing the following medication for administration: 1. Keppra one cubic centimeters (cc) equal to 100 milligram (mg). 2. [redacted] 75 mg one tablet. 3. Namenda 5 mg one tablet. 4. Lasix 40 mg one tablet. 5. Acetazolamide 250 mg one tablet. LVN 2 was observed placing each solid medication in individual plastic envelope and crush them one at a time. Then LVN 2 was observing checking the GT for placement by instilling 50 cc of air into the resident's stomach following by aspiration of content to assess the residual. There was no residual. Then LVN 2 flushed the GT with 10 cc of water and started with administration of medications. First LVN 2 purred liquid Keppra into a barrel of the syringe connected to the GT following with 10 cc of water flush. Then, LVN 2 purred the dry (powdered) crushed Namenda into a barrel of the syringe following with 10 cc of water. It was noted that the medication was not running down through the GT. LVN 2 started shaking the syringe in order to dilute powdered medication inside the tip of the syringe without success. Then, LVN 2 attempted to empty the content of the barrel of syringe into a medicine cup by inverting the syringe barrel. When the Evaluator intervened, LVN 2 added approximately 30 cc of water and medication passed through the GT.	F 425	F 425: Immediate Action: LVN 1 was immediately in-serviced by the DSD on administrating medication via enteral feeding tubes. LVN 2 was immediately in-serviced by the DSD on the procedure for administrating non-crushable medications via enteral feeding tubes. Identification of other affected residents: All License Nurses were in-serviced by the DON on 8/30/2012 for: Med Pass: Review of Med Pass discrepancies/policy and procedures. Systematic Changes: Pharmacy Nurse Consultant will conduct Med Pass reviews for all License Nurses at least quarterly. Quality Assurance: All License Nurses were in-serviced by the DON on 8/30/2012 for: Med Pass: Review of Med Pass discrepancies/policy and procedures. Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/30/12

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F 425	Continued From page 15 Then LVN 2 proceeded to administer remaining three crushed/powdered medications without first diluting the medication with water before pouring into the barrel of a syringe. LVN 2 pouring the dry powdered medications following with 10 cc of water and waiting for the medication to get through the GT. During an interview with the LVN 2 on August 18, 2012, at 10:30 a.m., she stated she was very nervous therefore, she did not administered medications the correct way. A review of the facility's policy and procedure on GT Medication Administration indicated that the licensed nurse had to validate GT placement by injecting 10 cc of air into the tubing and auscultating the abdomen. Then after aspiration for stomach content to check the amount of residual the licensed nurse had to flush tubing with 30 cc of water. The policy and procedure indicated the licensed nurse had to dilute the crushed medication with 30 cc of water before administration thorough the GT b. On August 18, 2012, at 8:40 a.m., during the medication pass LVN 1 was preparing the following medications to be administered to Resident 11. 1. Iron 325 mg one tablet. 2. Colace 100 mg one tablet. 3. Aspirin EC 81 mg one tablet (EC-enteric coated a barrier applied to oral medication that controls the location in the digestive system where it is absorbed. Enteric refers to the small intestine, therefore enteric coatings prevent release of medication before it reaches the small intestine).	F 425		

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F 425	Continued From page 16 4. Multivitamin with minerals one tablet. 5. [redacted]5 mg one tablet. 6. Metoprolol 50 mg one tablet. 7. Lisinopril 20 mg one tablet. 8. Amlodipine 10 mg one tablet. LVN 1 was observed to place all of the above medications (including the enteric coated Aspirin) in one plastic envelope and crushed them together. Then LVN 1 mixed all the crushed medications with an apple sauce and administered to the resident. According to the current standard of nursing practice it is indicated that the potential for drug-drug interactions [as well for those involving excipients (ensuring that the active ingredient stays "active) increases when two or more dosage forms are crushed together. Crushing involves applying significant force to a drug product, and it increases the amount of particulates surface area available for interaction. Either can accelerate changes in the molecular structure and result in altered physical and chemical properties; such risks increase exponentially when more than one drug, with its excipients (active ingredient) is crushed." (American Journal of Nursing: Drug Administration, Through Enteral Feeding Tube, Joseph I. Boullata, PharmD. October 2009, Vol. 109 No. 10 pages 34-42). According to the admission record, Resident 11 was admitted to the facility on September 29, 2000, with diagnoses that included diabetes mellitus, congestive heart failure, gastrointestinal malignancy and gastrointestinal bleeding. The Minimum Data Set assessment dated June	F 425		

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F 425	Continued From page 17 27, 2012, indicated the resident had a moderately [redacted] and totally dependent on staff for activities of daily living. There was a physician's order dated May 30, 2003, for Aspirin 81 mg delayed release daily for prophylaxis of cerebrovascular accident. The physician's order indicated to "do not crush". The physician's order also indicated that only crushable medications may be crushed. During an interview with the Director of Nursing on August 18, 2012, at 11 a.m., she confirmed that LVN 1 should not crushed enteric coated Aspirin. DON said the licensed nurse administering medication should check to see that there is no contraindication to crush the medication in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in appropriate form or contact the physician to change the medication. DON said enteric coated tablets are designed to pass through the stomach whole and then dissolve in the intestinal tract.	F 425		
F 431 SS=D	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.	F 431		

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F 431	Continued From page 18 Drugs and biologicals used in the facility must be 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 and interview, the facility failed to ensure the medications such as Insulin was kept in the medication cart and was kept locked at all times. Findings: On August 18, 2012, at 1:30 p.m. on Station B, it was noted that nine Insulin vials were kept on the medication cart in the hallway without the licensed nurse being present. At 1:31 p.m., during	F 431	F-431: Immediate Action: The LVN immediately placed insulin vials under lock. The LVN was in-serviced immediately by the DSD on MED PASS: storage and proper handling of medications. Identification of other affected residents: No other residents were affected. Systematic Changes: All License Nurses were in-serviced by the DON on 8/30/2012 for: Med Pass: Review of Med Pass discrepancies/policy and procedures. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/30/12

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F 431	Continued From page 19 an interview, the Registered Nurse (RN) 1 stated that they needed to kept locked. There was no residents in the hallway at the time.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

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F 441	Continued From page 20 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to label residents' oxygen tubing, with a date indicating when they were changed and failed to keep them off the floor, and failed to ensure the laundry washing machine hot water temperature was maintained at 160 degrees Farenheit, for the for three out of 15 sample residents (7,10,16). Findings: a. On August 16, 2012, 6:05 p.m., it was observed that Resident 7's and 16's oxygen tubing, had no label on them to indicate the date when they were last replaced. Resident 7's tubing was on the floor. The Director of Staff Development stated that the oxygen tubing needed to be labeled with a date. She also confirmed there were no labels indicating when the tubings were last changed. b. On August 16, 2012, 6:10 p.m., it was observed that Resident 10's oxygen tubing, had no label on it to indicate the date when it last replaced. Also it was noted that tubing was on the floor. The resident was actively receiving oxygen through nasal cannula at the time of observation. The Registered Nurse 1 (RN 1) during an interview on August 16, 2012, at 6.10 p.m., stated that the oxygen tubing needed to be labeled with	F 441	F-441: THIS TAG IS UNDER DISPUTE: F-441: Immediate Action: 1. The Oxygen Tubing of Residents 7, 10, and 16 was replaced immediately, placed so the tubing did not touch the floor, and the date of replacement was indicated on the tubing. 2. Regarding proper hot water temperatures for the Facility's washing machines, based on CMS Manual System, Department of Health & Human Services (DHHS) Pub. 100-07 State Operations Provider Certification dated 12/9/2009, Facility practice was according to regulations (see attached page 1). The Laundry Service Consultant was called to evaluate the appropriateness of the Laundry services procedures and practices, and found the Facility in compliance with regulations (see attachment 2). Identification of other affected residents: All residents with oxygen orders were checked to ensure a) Oxygen tubing were properly placed off the floor, and b) were all dated.	8/31/12

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F 441	Continued From page 21 a date. She also confirmed there was no label indicating when the tubing was last changed. c. On August 18, 2012, at 9:15 a.m., during an observation of the laundry room, the washers only reached 152 degrees Fahrenheit. According to the laundry staff it should be 160 degrees Fahrenheit; however they normally monitor the temperature at the hot water holding tank which was above 160 degrees Fahrenheit. They were not monitoring the dryer temperatures. According to the California Uniform Plumbing Code, Section 1011-1012, page 95.1, The required temperature of 160 degrees Fahrenheit in the laundry is that measured in the washing machine and shall be supplied so that the temperature may be maintained over the entire wash and rinse period. A lower temperature of 140 degrees Fahrenheit may be utilized, provided linens are subsequently passed through a tumbler dryer at 180 degrees Fahrenheit or a flatwork ironer at 300 degrees Fahrenheit.	F 441	Systematic Changes: All License nurses as well as All Certified Nursing assistants ("CNAs") were in-serviced by the DON and DSD on standard care practices: Handling Oxygen Tubing. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure all the bedrooms measured at least 80 square feet per resident in multiple resident bedrooms for 14 out of 27 bedrooms.	F 458		

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F 458	Continued From page 22 Findings: During the initial tour of the facility on March 10, 2010, there were 2 beds in Rooms 21, 23, 24, 25,26, 27, 28, 33, 34, 35, 36, 37 and 38. These bedrooms measured less than 160 square feet. In Room 22, there were 4 beds and measured less than 300 square feet. A review of the Client Accommodation Analysis disclosed the room measurement as follows: Room Bed Square Feet 21 2 147.40 22 4 290.28 23 2 147.40 24 2 147.40 25 2 147.40 26 2 147.40 27 2 147.40 28 2 147.40 33 2 147.40 34 2 147.40 35 2 147.40 36 2 147.40 37 2 147.40 38 2 147.40 The space available for the residents was sufficient to provide access and freedom of movement.	F 458	F 458: Immediate Action: Facility has approval for waiver of rooms in question. The waiver was given to the surveyor. Identification of other affected residents: No other residents were affected at the room size meets the regulation. Systematic Changes: The facility will continue to apply for the appropriate waiver on an annual basis. Quality Assurance: The Administrator/designee will review all waivers on an annual basis for proper submission.	8/18/12
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463		

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F 463	Continued From page 23 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the call light system was in operating condition for one of two shower rooms. Findings: During the tour of the facility on August 18, 2012, at 2 pm, accompanied by the maintenance staff and the administrator, the surveyor observed two of three call light switches in the tub/shower room at Station A not working. The maintenance staff stated they were not aware that the switches for the shower room were not working and would fix them right away.	F 463	F 463: Immediate Action: The maintenance department immediately corrected the faulty call light switches in the Station A tub/shower room. Identification of other affected residents: No residents were affected by the faulty call light switches. Systematic Changes: The maintenance department will round weekly to ensure all call light switches are in working conditions. The License Nurses will notify the maintenance department of any faulty light switches in between weekly rounds. Quality Assurance: Any non-compliance will be corrected immediately. A report shall be made to the Quality Assurance and Assessment committee for further review and recommendations.	8/18/12