STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056345	A. BUILDING _____ B. WING _____	02/11/2016

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SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the recertification survey visit from 2/8/16 to 2/11/16 Representing the department: Health Facilities Evaluator Nurses: 35388, 09795, 35644 The resident census at the start of the survey was 54.	F 000		3/26/16
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility applied a restraint to one (Resident 3) of 14 sampled residents without a physician's order or an indication for use. This failure had the potential to restrict the resident's freedom of movement and cause a decline of this resident's physical functioning. Findings: During a review of the clinical record for Resident 3, the admission record indicated Resident 3 was admitted 1/15 with diagnoses that included a stroke and right side hemiplegia (paralysis of right side of the body). A review of the doctor's orders dated 12/28/15 for Resident 3 showed an order to discontinue use of a lap cushion (a foam cushion that fit into the fame of a wheelchair) because she had no attempts of trying to get out of the	F 221		

RECEIVED
MAR 28 2016
Licensing & Certification
East Bay District Office

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/25/16

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.

accepted 3/29/16 B.D.

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F 221	Continued From page 1 wheelchair. During an observation on 2/8/16 at 12:05 p.m., Resident 3 was observed sitting up in the wheelchair. A lap cushion was firmly placed within the frame of Resident 3's wheelchair. The lap cushion prevented Resident 3 from moving forward in the wheelchair. During an interview with Certified Nursing Assistant 1 (CNA 1) on 2/8/16 at 12:07 P.M., he stated he placed the lap cushion on Resident 3's wheelchair every time she got up in the wheelchair. He further stated the lap cushion was used to prevent Resident 3 from leaning forward in the wheelchair. A review of the facility's certified nursing assistant assignment sheets indicated CNA 1 was assigned to care for Resident 3 nine times in January 2016 and 3 times in February 2016. During an interview with the Director of Nursing (DON) on 2/9/16 at 12:10 p.m., the DON stated "it was a mistake" that the lap cushion had been placed on Resident 3. The DON acknowledged the lap cushion had been discontinued 12/28/15. The facility's policy and procedure titled "Physical Restraints" dated 9/1/08 indicated a lap cushion was a form of a restraint. The policy and procedure also indicated a physician order was needed for use of any restraint.	F 221	**1. Specific action and/or measures to correct the deficiency.** The lap buddy was immediately removed from the resident's wheelchair. **2. Who will be directly responsible for the corrective action.** The facility will ensure that staff will not apply any restraint without MDs order and RP/ resident consent. **3. What measures will be put in place to ensure that the deficient practices does not recur.** DON, ADON/ Nursing Supervisor/ DSD/ designee will check the residents with orders for restraints to make sure that they are properly applied, the order is in-placed and consents are in-placed. **4. How the facility plans to monitor its performance to make sure that solutions are sustained** The DON/ ADON/ Nursing Supervisor/ DSD/ designee will check all residents with restraints to ensure that the order is in-placed, the consent is in-placed and when it gets discontinued, that DON/ ADON/ Nursing Supervisor/ DSD/ designee will communicate to staff and will be discussed with IDT member during Facility QA Meeting on a monthly basis to ensure compliance and will take appropriate actions as needed	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		

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F 246	Continued From page 2 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review for two of two random sampled residents (15 and 16) the facility failed to ensure that both residents call lights were in reach. This failure put residents at risk for not receiving care and services. Findings: 1. Record review on 2/10/16 at 9:50 AM showed Resident 15 was admitted to the facility on 1/8/16 with diagnoses including intracerebal hemorrhage(bleeding in brain) and left sided hemiplegia (Paralysis on left side). Resident 15 care plan showed that the resident had deficits with his activities of daily living (ADLS), decrease mobility, due to intracerebral hemorrhage, and left sided weakness. One of the interventions were to encourage the resident to use bell to call for assistance. In addition, the resident had a problem with communication related to weak or absent voice and risk for falls. The interventions were to be sure the resident's call light was within reach, encourage the resident to use the call light for assistance and resident needed prompt response to all request for assistance. During the initial tour on 2/8/16 at 7:30 AM, and	F 246	**1.Specific action and/or measures to correct the deficiency.** Resident 15's call light was made sure that it was placed on his right hand and Resident 16's call light was made sure that his call light was within his reach. **2. Who will directly responsible for the corrective action.** The facility will ensure that all staff will make sure that all call lights are within reach of the residents at all times.	3/26/2

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F 246	Continued From page 3 on 2/9/16 at 7:30 AM Resident 15 was observed in bed with his left upper extremity flaccid and he was moving his right upper extremity. Resident 15 call light was placed on the night stand behind the bed. On 2/9/16 at 7:35 AM during interview with LVN 2 outside Resident 15 room when asked if Resident 15 could use his call light, LVN 2 went into the room to check the resident, found call light and put it near the resident on his right side. Resident 15 turned on the call light. On 2/10/16 at 7:40 AM Resident 15 call light was over the night stand out of his reach. Again, on 2/11/16 at 10:15 AM the call light was positioned on Resident 15 left side out of reach. 2. Record review on 2/10/16 at 9:50 AM showed that Resident 16 was Re-admitted on 1/15/16 with diagnoses including Parkinson Disease. The care plan dated 1/23/16 showed that Resident 16 was high risk for falls related to Parkinson Disease and history of falls. The care plan 1/23/16 continued to show that Resident 16 had an unwitnessed fall with no injuries. The interventions for Resident 16 were need a safe environment with even floors, free from spills, glare free light, a working and reachable call light, and bed in low position at night. During the initial tour on 2/8/16 at 7:30 AM Resident 16 was observed sitting in his wheelchair reading the paper. Resident 16 call light was observed over the night stand behind the bed. Resident 16 stated, "call light was never where I need it." On 2/10/16 at 7:40 AM Resident 16 was sitting in his wheelchair eating breakfast	F 246	**3.What measures will be put in place to ensure that the deficient practices does not recur.** DON/ ADON/ Nursing Supervisor/ designee will provide ongoing in-services to staff regarding having the resident's call lights within their reach at all times . **4.How the facility plans to monitor its performance to make sure that solutions are sustained.** DON/ ADON/ Nursing Supervisor/ DSD/ designee will do rounds on ongoing basis to make sure that the resident's call lights are within their reach at all times. These rounds will be reviewed on a monthly basis by the QA team to ensure compliance and the facility will actions as needed	

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F 246	Continued From page 4 and the call light was on the night stand out of reach. During interview on 2/11/16 at 6:58 AM CNA 2 stated that everyone answers the call lights right away and call lights are kept in reach of residents.	F 246		
F 252 SS=B	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a clean, safe and homelike environment for the residents. This failure had the potential to cause an unpleasant environment for the residents. Findings: During observation on 2/9/16 at 0900 a.m., with the Maintenance Staff (MS), the following things were noted: 1. Laminated bathroom flooring between room 3 & 4 had a 24 inches in diameter brown discoloration around the toilet. The housekeeper was observed cleaning the area but was not able to remove the discoloration. 2. Two green chairs in dining gallery room accessible to residents and visitors had torn vinyl seats. 3. Two skylights in the main dining/activity room had green debris on the glass blocking the	F 252	F 252 **1. Specific action and/or measures to correct the deficiency.** A. The laminated flooring in rooms 23 and 4 have been e placed with new flooring B. The two green chairs in the gallery dining room have been replaced by new furnitures C. The two sky lights have been cleaned and are now free of debris D. The medium sized garbage cans have been removed E. The toilet seat was installed in bathroom 17 F. The toilet seat was replaced with a a new toilet seat in bathroom 20 G. Toilet paper has been replaced for bathrooms 20 and 21 and bathrooms 17 and 18 have been properly cleaned and free from debris H. There are no more flies in rooms 20 and 24. Pest control services have been called	3/26/2016

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F 252	Continued From page 5 sunlight. 4. One medium size garbage can was uncovered and overflowing with garbage spilling to the ground. 3. During the initial tour on 2/8/16 at 7:30 AM the following was observed: a. Bathroom in room 17 had no toilet seat and around bowl of toilet was dry brown matter. b. Room 20 bathroom toilet seat soiled dry spots and no toilet paper on roll. c. On 2/9/16 at 7:35 AM bathroom for room 20 and 21 no toilet paper and rim of toilet had dark green fecal matter. The rim of the toilet for bathroom for room 17 and 18 had brown matter. d. Black flying insect observed in room 20 and 24 on 2/9/16. Resident in room 19 stated that "one or two was flying around pooping in my food." Resident 6 stated she had been bothered with flying insects for two weeks and she constantly fan it away from her food.	F 252	**2. Who will be directly responsible for the corrective action.** All other rooms and bathrooms were checked by maintenance department and facility managers to ensure compliance. Appropriate actions and resolutions were taken as needed. **3. What measures will be put in place to ensure that the deficient practices does not recur.** Maintenance supervisor and facility managers will conduct weekly rounds to ensure environmental compliance **4. How the facility plans to monitor its performance to make sure that solutions are sustained**	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	Monthly environmental in services will be conducted by the DSD. These in services will be reviewed by the QA team on a monthly services. Monthly environmental inspections for the entire building will be conducted by maintenance supervisor and facility managers. These will all be reviewed by the QA team on a monthly basis and appropriate action will be taken as needed.	

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F 314	Continued From page 6 Based on record review and staff interview for one of 14 sampled residents (Resident 7) the facility failed to ensure that the Resident 7 had on heel protectors to prevent pressure sores from developing. This failure put the resident at risk for developing pressures on the heels. Findings: Record Review on 2/8/16 at 10:30 am showed Resident 7 was admitted to the facility on 3/27/14 with diagnoses including muscle weakness and Parkinson's Disease. Review of care plan shows potential pressure ulcer development related to decrease mobility. The physician order sheet for February 10, 2016 contained an order dated 11/7/14 for bilateral heel protectors while in bed. On 2/9/16 at 9;00 AM Resident 7 was lying in bed with no heel protectors. CNA 3 stated that the resident does not have pressure sores. Observed that Resident 7 was not wearing heel protectors. On 2/10/15 at 7:15 AM Resident 7 was lying in bed with both eyes closed and not wearing heel protectors. The facility policy, Wound and Skin Management, "To identify residents at risk for developing pressure sores or other skin conditions and track and trend. To provide routine preventative measures and care specific to resident's individual risk factors needs. To prevent skin breakdown and to administer care/treatments as ordered by the physician.	F 314	**1.Specific action and/or measures to correct the deficiency.** Resident 7 's heel protectors were immediately applied to her while she was in bed. **2. Who will directly responsible for the corrective action** All residents have the potential to be affected. The facility will ensure that staff will apply the heel protectors as ordered to prevent developing pressure sores on the heels. The facility will evaluate all other residents to ensure that heel protectors are in place as ordered. **3.What measures will be put in place to ensure that the deficient practices does not recur.** DON/ ADON/ Nursing Supervisor/ DSD/ designee will provide in-services to staff on ongoing basis regarding application of heel protectors as ordered to prevent developing pressure sores on the heels.	3/26/2016

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F 328 F 328 SS=D	Continued From page 7 483.25(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 review, the facility failed to give proper treatment and care for one resident (9) with a peripherally inserted central catheter (PICC) in a sample of 14 residents. They did not follow their policy by not measuring the external length of the PICC (small tube inserted into blood vessel in the arm and advanced into a major blood vessel in the chest). This failure had the potential that a change in the position of the PICC in the body would not to be noticed, which could result in complications that could affect the resident's health or the placement of the PICC line could be compromised. Findings: During a review of the clinical record for Resident 9, the admission record showed the resident was admitted 1/16 with diagnosis of infected left hip. The physician orders dated 1/28/16 included orders for Resident 9 to receive intravenous	F 328 F 328	**4.How the facility plans to monitor its performance to make sure that solutions are sustained.** DON/ ADON/ Nursing Supervisor/ DSD/ designee will do rounds on ongoing basis to ensure that heel protectors are applied to residents as ordered to prevent developing pressure sores. Ongoing rounds and implementations will be conducted by DON/DSD/Nurse Manager to ensure compliance. These in-services will be given to QA team for review. F328 **1.Specific action and/or measures to correct the deficiency.** Resident 9's PICC line placement or resident's condition was not affected or compromised. The facility is now measuring the external length of the PICC line with dressing change Q weekly.	3/31/2016

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F 328	Continued From page 8 antibiotics through a PICC line in his right arm twice a day. During an observation and concurrent interview on 2/10/16 at 11:55 a.m., the dressing to the PICC line in Resident 9's arm was observed to be peeling off at the lower end of the dressing. Resident 9 stated that the nurse planned to change the dressing that day. During an interview with Registered Nurse 1 (RN 1) on 2/10/16 at 2:45 p.m., RN 1 stated she changed the dressing to Resident 9's PICC line on that date. RN 1 stated she did not measure the external length of the PICC line catheter when the dressing change was done. She further stated she never measured the external length of any PICC line. RN 1 stated she received training in PICC line care from "VIC the PICC" (a company that inserts PICC lines and provides education on care of PICC lines). During an interview with the Director of Nursing (DON) on 2/11/16 at 10:20 a.m., the DON stated the nurses at the facility do not measure the external length of PICC lines. During a telephone interview with the Registered Nurse Educator (RNE) from "VIC the PICC"on 2/11/16 at 11:08 a.m., the RNE stated the the external length of the PICC line should be measured and documented with each dressing change. The RNE further stated that this information was taught in the classes "VIC the PICC" provided to nurses. The facility's policy and procedure titled "Dressing Change for Vascular Access Devices" dated 2008, indicated that after removing the old	F 328	**2. Who will directly responsible for the corrective action.** Facility will have RN staff to measure PICC line external length and document it with each dressing change for all patients with PICC line. Facility conducted inspection all patients with PICC lines to ensure proper compliance. **3.What measures will be put in place to ensure that the deficient practices does not recur.** Facility will have in-services for RN staff from VIC the PICC to provide education on the care of PICC lines. **4.How the facility plans to monitor its performance to make sure that solutions are sustained.** The DON/ ADON/ Nursing Supervisor/ DSD/ designee will ensure that RN staff are measuring and documenting the external length of the PICC line each dressing changes. Ongoing monitoring and inspections will be conducted to ensure compliance. These findings will be reviewed by QA team and appropriate actions will be taken as needed.	

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F 328	Continued From page 9 dressing from the PICC the nurse should assess the external length. of the catheter. PICC migration (change in postion of the PICC) may result fom excessive sneezing, coughing or vomiting. External migration may require replacement of the PICC or a change in therapy. (reference: Lippincott's Nursing Procedures, Sixth Edition, 2013, pg. 570)	F 328		
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. 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	F 431	**1.Specific action and/or measures to correct the deficiency.** The identified discontinued medication was immediately removed and properly reconciled and then was placed on the narcotic storage to be destroyed when the Pharmacist comes. **2. Who will directly responsible for the corrective action.** Facility will make sure that all staff will have to remove all discontinued medications from the medication refrigerator and medication carts as soon as the MD orders to have the drug discontinued.	3/26/2016

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F 431	Continued From page 10 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 destroy a medication that had been discontinued as per the facility's policy. This failure had the potential for one (Resident 4) of 14 sampled residents to receive a medication that was discontinued by the physician. Findings: During a review of the clinical record for Resident 4, the physician's orders showed an order written 11/20/15 to discontinue Marinol (drug used to treat nausea, vomiting, and to stimulate appetite). Marinol is obtained from marijuana and is a controlled medication (drug that has a potential for abuse). During an observation of the medication room with the facility's Director of Nursing (DON) on 2/9/16 at 2 p.m., a container of Marinol labeled for Resident 4 was noted in the medication refrigerator. The label indicated the medication had been filled on 11/16/15. During an interview with the DON on 2/9/16 at 2:10 p.m., she stated the Marinol should not be in the refrigerator. The DON stated discontinued controlled medications are stored in a locked cabinet in the DON's office until they can be	F 431	**3.What measures will be put in place to ensure that the deficient practices does not recur.** DON/ ADON/ Nursing Supervisor/ DSD/ designee will provide ongoing in-services for Licensed staff regarding removing discontinued medications immediately after the MD orders it to be discontinued and place it to the proper storage area appropriately. **4.How the facility plans to monitor its performance to make sure that solutions are sustained.** DON/ ADON/ Nursing Supervisor/ DSD/ designee will do a routine checks to ensure at all discontinued medications are immediately removed from the medication refrigerator or medication carts and are properly stored for return or destruction with the Pharmacist. The in-services and inspections findings will be reviewed by QA team on a monthly basis.	

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SAN LEANDRO HEALTHCARE CENTER	368 JUANA AVENUE SAN LEANDRO, CA 94577

(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 431	Continued From page 11 destroyed with the Pharmacist present. The facility policy and procedure titled "Disposal of Medication, Syringes and Needles. Discontinued Medications" dated 2007, indicated when medications are discontinued by prescriber order, the medications are marked as discontinued and destroyed or returned to the issuing pharmacy. Controlled medications may not be returned to pharmacy.	F 431		
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 interview the facility had 18 multiple resident rooms that measured less than 80 square feet per resident for the 50 residents who would occupy those rooms. This limited the space for providing resident care by facility staff and increases the risk for residents not being able to have enough space to accommodate their personal belongings Findings: The rooms were identified and the square feet per bed were as followed: Room 7 had four beds and it measured 12 ft 9.5 inches by 22 ft 4 inches providing 71.42 ft. per resident. Room 8 had four beds and it measured 12 ft. 7 inches by 22 ft. 4 inches providing 70.256925 ft. per resident. Room 9 had four beds and it measured 12 ft. 7	F 458	**1.Specific action and/or measures to correct the deficiency.** The facility was given a waiver for room size on the identified rooms	3/28/2016

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F 458	Continued From page 12 inches by 22.4 ft. 4 inches providing 70.2569 ft. per resident. Room 10 had four beds and it measured 12ft.6.75 inches by 22 ft. 4 inches providing 70.140625 ft. per resident. Room 11 had two beds and it measured 12 ft 5.5 inches by 11 ft 7 inches providing 72.1545 ft. per resident Room 12 had two beds and it measured 12 ft. 5 inches by 11 ft. 9 inches providing 72.94791 ft. per resident. Room 14 had two beds and it measured 12 ft 5 inches by 11 ft. 9 inches providing 72.947915 ft. per resident. Room 15 had two beds and it measured 12 ft 5.5 inches by 11 ft. 9 inches providing 73.1927 ft. per resident Room 16 had two beds and it measured 12 ft, 5.5 inches by 11 ft. 9 inches providing 73, 1927 per resident Room 17 had two beds and it measured 12 ft, 5.5 inches by 11 ft. 9 inches providing 73, 1927 per resident Room 18 had two beds and it measured 12 ft inches by 1 inches providing 72.703125 per resident Room19 had two beds and it measured 12 ft inches by 11 ft 8.5 inches providing 72.4453 per resident Room 20 had three beds and it measured 11 ft 8,5 inches by 18 ft. 2 inches providing 70.900333 ft. per resident Room 21 had three beds and it measured 11 ft 9 inches by 18 ft. 1 inch providing 70.8263 ft per resident Room 22 had three beds and it measured 11 ft. 9 inches by 18 ft. 1 inch providing 70.82633 ft. per resident Room 23 had three beds and it measured 11 ft. 9	F 458	2. Who will directly responsible for the corrective action. 3.What measures will be put in place to ensure that the deficient practices does not recur. 4.How the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 458	Continued From page 13 inches by 18 ft. 1 inch providing 70.82633 ft. per resident Room 24 had three beds and it measured 11 ft. 10 inches by 18 ft 1 inch providing 71.3287 ft. per resident Room 25 had three beds and it measured 11 ft. 9 inches by 18 ft. 1 inch providing 70.826 ft. per resident During observations throughout the survey,there was adequate room for residents' personal belongings and for wheelchair use. In an interview on 2/10/16 at 12:1., Resident 13 stated she had enough space in the room and the staff had enough space to provide any care she needed. During the group interview, there were no concerns raised regarding safety and adequate space for care. Staff was able to provide nursing services to meet the individual needs of each resident. The rooms were maintained in a reasonable uncluttered manner. There were no negative consequences attributable to the decreased space in any of the rooms and no safety concerns were observed.	F 458		
F 469 SS=B	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain an effective pest control	F 469	**1.Specific action and/or measures to correct the deficiency.** A. The gaps that were identified have been sealed B. All sliding doors screen and bathroom screens have been fixed or replaced C. The pest control service has successfully eliminated the flies	3/26/2016

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F 469	Continued From page 14 program for insects. This failure had the potential for the pest and insects to cause and spread diseases in the facility. Findings: 1. During observations on 2/9/16 through 2/11/16, the glass front door entrance had varying sizes of gaps observed. The top of the door had a ½ inch gap, the middle part of the door had ¾ inch gap, and the lower part of the door had 1inch gap. There were dried leaves and dust noted that were able to get through the door. 2. During observation on 2/9/16 at 0830 a.m., there were four bathroom screens and eight sliding door screens with holes, gaps and bent frames. During an observation and interview on 2/9/16 at 0946 a.m. with the Maintenance Staff (MS) small black colored insects were observed flying in resident's bathroom. The MS acknowledged observing the small black colored flying insects. He also confirmed the holes, gaps and bent frames on the four bathroom screens and eight sliding door screens and the varying sizes of the gaps on the glass front door entrance and stated that insects and flies could enter thru the gaps.	F 469	**2. Who will directly responsible for the corrective action** The maintenance department checks all doors, windows and screens to ensure compliance **3.What measures will be put in place to ensure that the deficient practices does not recur.** The facility will conduct ongoing rounds and inspections to ensure compliance on the issues identified **4.How the facility plans to monitor its performance to make sure that solutions are sustained.** These ongoing inspections and rounds will be reviewed by te QA team on a monthly basis and appropriate action will be taken as needed.	
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. This REQUIREMENT is not met as evidenced by:	F 518	**1.Specific action and/or measures to correct the deficiency.** The employee identified was given an in-service again regarding the location of the emergency water shut off.	3/26/2016

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F 518	Continued From page 15 Based on observation and interview the facility failed to ensure that one of nine staff members, License Vocational Nurse (LVN) 1, knew where the emergency water shut-off valve was located. This failure had the potential to threaten the health, safety and care of residents during an emergency. Findings: During an observation and concurrent interview on 2/9/16 at 2 p.m., LVN 1 was not able to show the correct location of the water shut-off valve. LVN 1 pointed to the large red pipe sticking upward from the ground. He also stated that he could not remember how to shut it off. LVN 1 stated he attended the last emergency training on 10/29/14. During concurrent interview on 2/9/16 at 2:30 p.m., Director of Staff Development (DSD), stated that the water shut-off is located outside the building by St. Rosa St water utility box.	F 518	**2. Who will directly responsible for the corrective action.** The facility will ensure to provide an ongoing in-service to all staff regarding the location of the emergency water shut off. **3.What measures will be put in place to ensure that the deficient practices does not recur.** DON/ ADON/ Nursing Supervisor/ DSD/ designee will provide an ongoing in-service to all staff regarding the location of the emergency water shut off. **4.How the facility plans to monitor its performance to make sure that solutions are sustained.** The DON/ ADON/ Nursing Supervisor/ DSD/ designee will do random checks on staff to ensure that they are able to show the location of the emergency water shut off. The ongoing inspection and in-services will be reviewed by the QA meeting on a monthly basis and appropriate action will be taken as needed.	