STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055345	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE GLEN CARE CENTER	330 MISSION ROAD GLENDALE, CA 91205

(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. Complaint #: CA00294814 - Unsubstantiated. Representing the Department of Public Health: [redacted] RN, HFEN [redacted]N, HFEN Total Population: 94 Sample Size: 18	F 000		
F 164 SS=D	Highest S/S= E 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164	*LVN #1 was immediately inserviced on privacy policy and procedure. He was observed during his next shift for compliance. *All nursing staff were inserviced about providing privacy during any care at all times. 2/2/12 *The DON and DSD will conduct rounds at random on daily basis to assure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ofrenia V. Ofrenia Castro | TITLE: RN/DON | (X6) DATE: 2/3/12

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

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	055845	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE GLEN CARE CENTER	350 MISSION ROAD GLENDALE, CA 91205

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F 164	Continued From page 1 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the licensed nurse failed to provide a resident full visual privacy during the administration of medication through a gastrostomy tube (GT) for one out of 19 sample residents (11). Findings: According to the admission record, Resident 11 was admitted to the facility on September 14, 2009, with diagnoses that included gastrostomy status, [redacted], diabetes Mellitus, Right breast cancer with mastectomy and peptic ulcer disease. The Minimum Data Set (MDS) dated October 18, 2011, indicated the resident was moderately impaired with cognitive skills for daily decision making, was totally dependent on staff for activities of daily living (ADL) and depended on a feeding tube for nutritional needs. On January 8, 2012 at 8:35 a.m., during a medication pass observation, Licensed Vocational Nurse 1 (LVN 1) was observed	F 164	*All the findings about daily rounds will be reviewed during QA meeting for any further interventions.	

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F 164	Continued From page 2 administering medications to the resident through a GT. LVN 1 uncovered the resident's abdomen during the medication administration. During this process, LVN 1 did not draw the privacy curtain closed exposing the resident to anyone walking into the room. On January 6, 2012, at 12 p.m. during an interview, LVN 1 acknowledged and indicated he should have closed the curtain all the way. The facility's policy and procedure titled "Personal Privacy" not dated, indicated in order to preserve personal privacy, staff shall keep privacy curtains pulled closed when administering personal procedures (shutting resident's door is insufficient).	F 164		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of	F 203	F203 *Facility IDT members met with the resident #17 to discuss discharge planning. The resident and family decided to have resident go home. *IDT members including SSD were inserviced on the providing a 30 day notice for all the discharges. Resident's discharge initiates on admission and plans may change according to resident's progress. *The administrator and DON shall monitor the compliance *Any further issues or concerns to be discussed QA meeting for further interventions.	2/2/12

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	055846	A. BUILDING _____ B. WING _____	01/11/2012

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F 203	Continued From page 3 individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and records review, the facility failed to ensure that a resident was provided with a 30 days advance notice before the facility intend to discharge the resident	F 203		

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F 203	Continued From page 4 or transfer the resident to another facility for one out of 19 sample residents (17). Findings: On January 6, 2012 at 11:25 a.m. Resident 17 was observed on a wheelchair moving around the hallway in the vicinity of the facility rehabilitation room. Resident 17 did not display any limitation to the upper limbs. On January 6, 2012, at 11:30 a.m. the resident requested to speak to a surveyor in the privacy of his room. During the interview the resident complemented on how well he liked his stay in the facility. When asked if he was still receiving any specialized rehabilitation, the resident answered that he was no longer receiving physical therapy or occupational therapy. Resident 17 stated that he would like assisted ambulation exercise so that he can regain strength of his legs. Resident 17 stated that he did not want to be dependant on the wheelchair when he goes home. A review of Resident 17's admission face sheet indicated that the resident was originally admitted to the facility on June 11, 2010, with the most recent readmission on October 19, 2011, with diagnoses that included history of falls, difficulty walking, high blood pressure, and anxiety. A review of a Minimum Data Set (MDS - a standardized assessment and care screening tool) dated December 17, 2011 indicated that Resident 17 did not have any problems with hearing, speech, and vision. The MDS indicated that Resident 17 did not have any problem	F 203		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 203	Continued From page 5 making himself be understood or understanding instructions. On January 9, 2012 at 8 a.m. Resident 17 was observed having breakfast and had a new roommate. During an interview on January 10, 2012 at 8 a.m. the resident stated that he was verbally notified by the facility Social Services Designee (SSD) that he was being transferred to another facility. When asked if his physician discussed about his discharge plans, the resident answered "No." During an interview on January 10, 2012 at 8:05 a.m. the facility SSD stated that the receiving facility will assess Resident 17 this morning. The facility SSD stated Resident 17 was planned to be discharged the following week. However, there was no evidence that indicated the resident or the resident's representative was issue a 30 days advance notice.	F 203		
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and records review, the facility failed to ensure that a resident	F 223	F223 *Resident #18 has been monitored for any physical or psychological distress as a result of this incident. No evidence of the above has been seen. *No other report of abuse (any kind) was reported by residents or staff *All staff inservice was conducted to review facility P&P on abuse prevention and reporting *The facility will continue education vice silverchair inservice at least on quarterly basis and maintain zero tolerance for any type of abuse.	2/2/12

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F 223	Continued From page 6 was not subjected to physical and verbal abuse from facility staff for one out of 19 sample resident (18). Findings: A review Resident 18's admission face sheet indicated that the resident was originally admitted to the facility on March 5, 2010, and readmitted on February 23, 2011, with diagnoses that included congestive heart failure, dysphagia (difficulty in swallowing), and aphasia (impairment to comprehend words usually resulting from brain damage). A review of the resident's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated December 9, 2011 , indicated that the resident had short-term and long-term memory problems and was severely impaired in skills for daily decision making, was totally dependent on the facility staff for activities of daily living (ADL) and received nourishment through a gastrostomy tube feeding system (GT feeding - stomach tube). On January 5, 2012, at 11 a.m. the facility's administrator stated that Licensed Vocational Nurse 4 (LVN 4) reported to him that Certified Nurse's Assistant 1 (CNA 1) scolded and slapped the resident's hand. During an interview on January 5, 2012 at 2 p.m. the facility administrator stated that he had suspended CNA 1 from working in the facility. On the same date at 11:30 a.m. the resident was observed sleeping in bed and did not had any sign of injury. During an interview on January 9, 2012 at 8:15	F 223		

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F 223	Continued From page 7 a.m. LVN 4 stated that CNA 1 asked her to change the resident's GT dressing that fell off during shower. LVN 4 stated that she saw CNA 1 slap Resident 18's left hand and told the resident " I told you to keep your hand on the armrest." During an interview on January 9, 2012 at 11 a.m. the facility director of staff development (LVN 2) stated that CNA 1 attended the facility mandatory abuse prevention in-service. A review of a facility's Abuse prevention and reporting class attendance record dated August 26, 2011 indicated that CNA 1 attended the in-service.	F 223		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident's belongings listed on the inventory list were collected by the residents or the responsible party and signed for after the expired in the facility as indicated on the facility's policy and procedure for one out of 19 sample residents (15). Findings:	F 224	F224 *Resident #15 family was called to see if they have wanted to pick up the belongings or wanted to donate to the facility. The response was that they wanted to donate the items. *All nursing staff and SSD were inserviced on P&P for discharge resident's belongings and documentation needed for the facility's actions. *DON will monitor for compliance on discharged residents. *Any identified issues will be reviewed during QA meeting for further evaluation and actions by the QA committee	2/2/12

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	056645	A. BUILDING _____ B. WING _____	01/11/2012

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F 224	Continued From page 8 A review of Resident 15's closed record indicated the resident was admitted to the facility on September 7, 2011, with diagnoses that included chronic obstructive pulmonary disease (COPD), Pacemaker and Atrial fibrillation. The resident had a personal inventory list dated September 7, 2011, on admission with the following items: two jackets, one blouse, one housecoat two pajamas and four tops, three shirts, seven pairs of socks, three underwear's, one eyewear, three pants, one wallet/purse and three combs. However, there were no evidence that indicated the resident or the resident's representative had collected the resident's belongings when the resident expired. The inventory form that indicates the signature of the person who collected the items was blank. On January 9, 2012, at 2 p.m., during an interview with Social Service Director, she stated there should be signature of the resident or responsible party, the facility staff who handed the belongings and the dates should also be completed. She stated she was not there when the resident expired or she must not have followed up with the inventory list for the Resident's personal effect. It must have been donated to the facility. However, there was no documentation that family had picked up the resident's personal effects. A review of the facility's policy titled "Discharging Resident's" dated August 2002, indicated upon discharge review the personal effects inventory list with the resident or responsible party and have them sign off that they have received all personal effects.	F 224		

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F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and records review, the facility failed to ensure that the licensed nursing staff provided care that met professional standards of practice and to follow the facility's policies and procedures related to gastrostomy tube feeding pump (1,2) and failed to ensure the resident's (4) hemodialysis access site was covered with a dressing for three out of 19 sample residents (1,2,4). Findings: a. On January 5, 2012 at 7:30 a.m. during a visit to Room 48 in the presence of Licensed Vocational Nurse 5 (LVN 5), Resident 1's GT (Gastrostomy tube - stomach tube) connected to a feeding pump indicated that a volume of 2313 milliliters (ml) of the formula Glucerna 1.5 had been infused. Resident 2 ' s GT feeding pump indicated that a volume of 2298 ml of the formula Jevity 1.5 had been infused. The display panels on both pumps indicated that both GT pumps were still infusing formula to Resident 1 and Resident 2. During an interview on January 5, 2012 at 7:30 a.m. LVN 5 stated that the GT pumps are programmed to deliver a fixed volume of formula and will automatically stop once the specified	F 281	F281 *The GTF orders for residents #1 and #2 were reviewed. The following shift licensed were inserviced on correct way of handling of feeding via kangaroo pumps. *All other residents on Gtube feedings were checked for any similar problem. No other issues were identified. *All licensed were inserviced on how to operate the kangaroo pumps and when to clear pumps as per protocol. *TF P&P was updtated to reflect the above and was approved by QA committee. *Random daily rounds to be made by DON/ADON/DSD to assure compliance.	2/2/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE GLEN CARE CENTER	338 MISSION ROAD GLENDALE, CA 91205

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F 281	Continued From page 10 volume is reached. A review of a physician's order dated January 2, 2012, for Resident 1 indicated that a volume of 1300 ml of the Glucerna 1.5 formula was to be infused in 20 hours. A review of a physician's order dated January 2, 2012, for Resident 2 indicated that a volume of 60 ml per hour of Jevity 1.5 was to be infused for 20 hours (for a total volume of 1200 ml). A review of a facility in-service conducted by the vendor's field representative dated November 7, 2011 regarding the "Kangaroo ePump" (a company trademark for a GT feeding pump) indicated a recommendation "to clear the volume when the daily volume total has been infused." A review of a facility "Gastric tube feeding via continuous pump" policy dated September 2004, did not include the practice that was recommended during the GT feeding pump in-service on November 7, 2012. During an interview on January 5, 2012 at 10:15, the facility director of nursing (DON) and the facility director of staff development (DSD) acknowledge that the facility GT feeding policy did not include instructions as to when the volume infused counter was to be cleared and that the policy was outdated and in need of revision. b. On January 6, 2012 at 7:50 a.m. during a visit to Room 40 in the presence of Licensed Vocational Nurse 5 (LVN 4), Resident 4 was observed asleep. The resident's hemodialysis catheter insertion site was not covered with a	F 281	*Resident #4 dressing was applied to hemodialysis site. *All other hemodialysis residents were checked to assure that the dressings were applied if needed *All licensed were inserviced on reinforcing the dressings to dialysis sites as per P&P *DON/ADON/RN Sup are to complete random rounds to assure compliance on daily basis.	2/2/12

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F 281	Continued From page 11 dressing and was exposed to air. A review of the physician admission orders dated January 3, 2012 indicated "may reinforce dressing to AV (arterial venous) shunt PRN (as needed). During an interview on January 6, 2012 at 7:50 a.m. LVN 4 stated that only facility registered nurses (RN) or the dialysis nurses are allowed to change the dressing on dialysis catheter insertion sites. A review of a facility policy on hemodialysis catheter dressing change dated August 16, 2006 indicated that " the hemodialysis catheter insertion site is a potential entry site for bacteria that could produce a catheter-related bloodstream infection ...Integrity of dressing is to be assessed every shift." During an interview on January 5, 2012 at 11 a.m. the facility administrator stated that a facility licensed vocational nurse (LVN 4) reported that she saw a facility certified nursing assistant (CNA 1) slap a resident ' s hand (Resident 18) and scolded the resident. A review of Resident 18 ' s medical record under licensed personnel progress notes did not indicate an entry regarding the alleged abuse incident. During an interview on January 9, 2012 at 8:15 a.m. LVN 4 stated that she reported the incident to the facility DON immediately but did not document the incident in Resident 18 ' s medical record. LVN 4 acknowledged that she should have documented the incident and stated that she would immediately make a late entry	F 281	*Please see POC on F223	

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F 281	Continued From page 12 regarding the incident in Resident 18's medical record under the licensed personnel progress notes.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the residents' environment free of accident hazards by not securing television sets in five residents' rooms to prevent the potential for accidents in the event of an earth quake. Findings: On January 4, 2012, between 8:45 a.m. to 10:25 a.m. during the initial tour of the facility on Station I with Licensed Vocational Nurse 2 (LVN 2), the television sets in Rooms 1 Bed-B, 3 Bed-A, 7 Bed-B, 8 Bed-B, and 14 Bed-B, were observed not secured to prevent potential accidents. On that same day at 11:20 a.m. during an interview, the maintenance supervisor stated the television sets should have been secured.	F 323	*Rooms 1B, 3A, 7B, 8B, 14B TV's were secured. *All other rooms that had TV's were checked and corrections were made if needed *Maintenance supervisor, the staff was inserviced about the need to secure all incoming TV's in the future *Random rounds will be made by Administrator and maintenance supervisor for compliance *Any identified issues will be reviewed in QA meeting for further interventions	2/2/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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	055846	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE GLEN CARE CENTER	330 MISSION ROAD GLENDALE, CA 91205

(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 371	Continued From page 13 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 observations and interview, the facility failed to ensure that residents' meals were prepared under safe and sanitary conditions. Findings: During a visit to the kitchen on January 6, 2012 at 2 p.m. the kitchen exhaust vent observed with a buildup of grease and dirt on the kitchen main exhaust vent. The exhaust vent was located directly above the meal preparation counters. These were the countertops were cooked meals were kept on hold and where residents plates were prepared. This was also the area in the kitchen where carts and trays were loaded before delivery to serve the residents meals. During an interview on January 6, 2012 at 2 p.m. the facility director of dietary services acknowledge that she was aware of the deficiency and that she will promptly have the facility maintenance supervisor clean the kitchen exhaust vent.	F 371	F371 *The exhaust vent was cleaned properly that same day *All other areas in the kitchen were inspected for any soiling and dirt. No other areas identified. *Administrator, DSD, and maintenance supervisor to conduct random rounds to check for compliance and make the necessary corrections. *The QA committee will review any further findings for additional interventions.	2/2/12
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		

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	055846	A. BUILDING _____ B. WING _____	01/11/2012

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F 425 SS=D	Continued From page 14 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and 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, the facility failed to ensure that ten medications (crushed solid and powder-metamucil) were each crushed separately and administered separately through a gastrostomy tube (GT) to prevent the potential for drug-drug interactions and cause changes in the properties of the drugs, lead to reducing the efficacy (power or capacity to produce a desired effect; effectiveness) and to flush the GT to prevent the potential for the clogging and the obstruction of the GT for one out of 19 sample	F 425	F425 *LN #1 was inserviced 1:1 on correct procedure on administration of medication via GT. *All LN's were inserviced by nurse consultant on correct administration of medication viz GT. Emphasis placed on not crushing and mixing medication and following pharmacy instruction on the medication cards. *The medication administration records for all Gtube feeder residents were checked for presence of Metamucil. Adjustments were made to change the time of administration of Metamucil to be 2 hours apart from other medications to help adequate absorption of medications. *Pharmacy consultant to pay particular attention to the above on the monthly medication regimen review *Findings from pharmacy review to be checked and followed up by DON and ADONs *All findings to be reviewed in quarterly QA meetings for further interventions.	2/2/12

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	055845	A. BUILDING _____ B. WING _____	01/11/2012

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F 425	Continued From page 16 residents (11). Findings: a. On January 5, 2012, at 8:35 a.m., during a medication pass observation, Licensed Vocational Nurse 1 (LVN 1) was observed administering medications to the Resident 11 via the gastrostomy tube (GT). LVN 1 crushed all the solid medications together, mixed the crushed medications and administered all the medications at the same time. The medications were: 1. Sucralfate 1 gram (GM) via GT two times a day and at bed times ordered on July 16, 2010, for peptic ulcer disease. 2. Multi-Vitamin with Minerals one tablet via GT every day ordered on July 17, 2010, as Supplement for Anemia due to gastric intestinal bleeding). 3. Diovan 80 mg via GT daily for hypertension. 4. Colace 100 mg via GT daily (hold for loose bowel movement. 5. Folic Acid 1 mg via GT daily for anemia. 6. Oscal with Vitamin D 500 mg via GT bid 7. Tylenol 500 mg via GT bid (pain management). 8. Ultram 50 mg 1 tablet via GT bid- headache 9. [redacted]we tablet every day 10. Metamucil two teaspoon mix with 8 oz of	F 425		

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F 425	Continued From page 16 water or juice through GT daily. Metamucil was scheduled for administration at 9 a.m. and 12 p.m. with other medications for the treatment of Diverticulosis. Metamucil a bulk-forming laxative is used to treat constipation. It absorbs liquid in the intestine, swells and forms a bulky stool which is easy to pass. This product may decrease the absorption of other medications the patient may be taking and should be taken at least 2 hours separate from other medications. (Monthly Prescribing Reference, March, 2010, Page 172). LVN 1 did not crush the solid medications separately and administer each medication separately. LVN 1 also did not administer the Metamucil at least 2 hours separate from the other medications. A review of literature indicated that the accepted standard of practice is to "Avoid mixing medications intended for administration through an enteral feeding tube. Most clinicians know that they should not mix different drugs in the same syringe without first ensuring the drugs' stability and compatibility; the same rule applies for solid and liquid dosage forms. It is hard enough to predict the stability for any one drug product altered for administration through a feeding tube; when more than one drug is administered at the same time, predicting stability and compatibility becomes even more difficult. Thus, when more than one drug is scheduled for administration, they must be given separately. 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. (American Journal Of Nursing, October 2009, Vol. 109 No.	F 425		

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F 425	Continued From page 17 10 pages 34 - 42, Drug Administration through an Enteral Feeding Tube, Joseph I Bollata PharmD, RPh, BCNSP. On that same day at 10:53 a.m. during an interview with Assistant Director of Nurses (ADON), after she reviewed the pharmacy recommendation on the bubble pack and also reviewed the (MAR), she stated the order should have been transcribed on the MAR and administered to the resident as ordered. She further stated since the pharmacy had indicated to administer the medication at least one hour before or one hour after vitamins/minerals it should have been done as indicated in the bubble pack. On the same date at 11 a.m. during an interview with the Staff Developer (DSD) stated the medications should have been crushed separately and administered separately. They verbalized lack of knowledge about Metamucil's interference with the absorption of other medications and the need to schedule Metamucil administration at a different time, at least two hours from the administration of other prescribed medications.	F 425		
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	F 431	F431 *All the formulas in the storage areas were checked and expired ones were removed. *All medication rooms were checked for any expired medications and if any present, they were removed. *All the insulin bottles were checked for expiration dates. No other ones were found. *The pharmacy consultant will perform monthly audits to check for all the above and outcome will be reported to QA meeting for further interventions 2/2/12	

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F 431	Continued From page 18 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 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 ensure stored Medications and Formulas were within the expiration dates, open multi-dose vial insulins were labeled with the date opened, and failed to ensure an Influenza Virus Vaccine bottles and insulin bottles were not stored beyond 28 days after the date opened according to current clinical standards, and that residents' medications were	F 431		

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F 431	Continued From page 19 stored separately from house supplies. Findings: a. On January 4, 2012, at 11:35 a.m., during the medication storage inspection on Station I, the following were observed: 1. There were two opened multidose vials of Influenza Virus Vaccines stored in the refrigerator. One of the vials was opened on November 14, 2011, and a second vial was opened but not dated. 2. There was a bottle of Lantus Insulin 100 unit open on December 6, 2011 still in the refrigerator. 3. There were nine bottles of Pulmocare 1000 milliliter (ml) used for Resident that are receiving enteral tube feeding. Seven of those formula expired on December 1, 2011, and two expired on September 1, 2011, were still in stock. 4. There were ten bottles of Glucerna 1.5 expired on November 1, 2011, was still in the storage room. 5. There was a bottle of Nepro 1000 ml expired on February 1, 2011. 6. There were two bottles of Cal HN expired on December 1, 2010, still in the storage room. During an interview with the LVN 11 on the same date at approximately 1:50 p.m. she stated opened multidose insulin is considered expired 30 days after open date of the vials. However, there was no policy for Formula storage provided	F 431		

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F 431	Continued From page 20 and the facility did not remove the formula after the expiration date. b. On January 4, 2012 at 10 a.m. during the medications storage inspection on Nursing Station II, in the presence of Registered Nurse 2 (RN 2) the following were observed: 1. There was one multi-dose open vial of Lantus insulin. 2. There was an open vial of multi-dose undated Novolog insulin. 3. There was an open bottle of Tussin DM cough syrup with a resident's name on the pharmacy label stored in the same shelf with house supplies. 4. There was a bottle of Cipro 250 milligram (mg) tablets with a resident's name on the pharmacy label stored in the same shelf with house supplies. During an interview on January 4, 2012 at 10 a.m. RN 4 acknowledged that it was a facility policy to discard injectable insulin 28 days after they have been opened. RN 4 also stated that it is a facility policy that injectable insulin is labeled with the date opened and the licensed nurse initials. RN 4 acknowledged that medications labled with the residents' name should not have been stored in the same shelf with house supplies. c. On January 4, 2012 at 11:30 a.m. during the central supply room inspection the following were observed: 1. There was a box of anti-microbial wipes with expired on September 2008. 2. There was a bottle of I-caps tablets expired on September 2011. 3. There was a bottle of Prosight tablets expired on September 2011. 4. There was a bottle of Vicks vapor rub expired on October 2011.	F 431		

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F 431	Continued From page 21 5. There was a bottle of Ferric X-150 tablets expired on November 2011. During an interview on January 4, 2012 at 11:30 a.m. the facility central supply custodian acknowledged that the expired medications and medical supplies should have been discarded and replaced.	F 431		