[redacted] accepted [redacted] 10/5/11

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

PRINTED: 09/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056334	A. BUILDING _____ B. WING _____	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSTAR REHABILITATION & NSG CTR OF SANTA MONICA	1340 15TH STREET SANTA MONICA, CA 90404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a recertification survey. Representing the Department of Public Health: [redacted] Total Population: 167 Sample Size: 24	F 000	**This plan of correction is submitted to the licensing agency pursuant to applicable law and constitutes the facility's credible allegation of compliance. This plan of correction does not constitute an admission of anything contained in the statement of deficiencies.**	
F 225 SS=D	Highest scope: F 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	**Immediate Corrective Action(s):** Upon verbal notification of alleged Deficient practice, the Director of Nursing immediately re-investigated the incident for Resident 9, by following the facility policy on Abuse prevention. Findings indicated that the etiology of the left hips fracture was non-trauma induced and osteoporotic related. Predisposing factors includes osteopenia as a result of osteoporosis. Further re-investigation and resident re-assessment revealed no evidence to substantiate any form of abuse.	7.21.2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robbie Banafshahn, [redacted] | TITLE: Admn | (X6) DATE

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

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F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to report, to the California Department of Public Health (CDPH), when 1 of 26 sampled residents (9) was transferred to a general acute care hospital's (GACH) emergency room, for evaluation following a complaint of pain to her left hip. Later, x-rays showed the resident sustained a left hip fracture. Failure to report injuries of an unknown origin to the appropriate authorities places residents at risk for continued injuries (unrecognized abuse, unrecognized medical condition and/or unsafe care of residents) and failure to protect residents from harm.	F 225	**Identification of Areas with Potential for Adverse Effect:** All incident reports filed and completed for 2011 were re-reviewed, and residents identified were re-assessed to assure that facility complied with the facility abuse prevention policy. None of the incident reports reviewed were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The Administrator provided an in-service on Sept. 21, 2011 to all Department Heads regarding the proper process to conduct incident reports/Abuse investigations. The DON also provided in-service on Sept. 11, 2011 to all nursing staff regarding incident report investigations to assure completeness of the information, as well as follow the facility Abuse Prevention Policy and Reporting protocol. **Monitoring Plan(s):** The DON/her designee will review all incident reports for completeness before documenting the report on the Incident Log. Findings will be discussed at the IDT meeting to determine the cause of incident/injury. Further investigation should be conducted by the Administrator if indicated to assure incident will be appropriately identified and be reported timely. Findings will be reported and discussed at the QAA meeting to assure compliance.	

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F 225	Continued From page 2 Findings: On July 20, 2011, at 7:00 a.m., Resident 9 was observed in her room, lying in bed. She motioned to her leg (s), a certified nursing assistant (CNA) was called to the room and it was determined the resident was complaining of pain to her leg(s). On July 20, 2011, at 10:30 a.m., during an interview, through an interpreter (activity director), Resident 9 stated she was walking upstairs exercising and she fell. She stated she did not remember who helped her up and did not feel pain until the next day. On July 21, 2011, at 12:15 p.m., during an interview, the director of nursing (DON) stated Resident 9 had a diagnosis of osteoporosis and they assumed the fracture was pathological. They did not report the fracture of unknown origin to the CDPH. During the investigation of complaint #CA00274178, a review of Resident 9's Admission Records, indicated she was readmitted to the facility on June 1, 2011, with diagnoses including status post ORIF (open reduction internal fixation) of the left hip, left intertrochanteric (hip) fracture, difficulty in walking, osteoarthritis (arthritis in the joints) and osteoporosis (weak bones). A Licensed Nurse Record, dated May 22, 2011, during the 3:00 p.m., to 11:00 p.m., shift indicated Resident 9 had complaints of pain, 8/10 (10 being worst pain and 1 being mild pain) to her left hip. She was assessed, given pain medication. The	F 225		

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F 225	Continued From page 3 physician was called and she was transferred to the acute care for evaluation. An x-ray result, dated May 22, 2011, indicated Resident 9 had a basicervical fracture of the left femur with counterclockwise rotation of the femoral head component (left hip fracture).	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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's nursing staff failed to investigate when 1 of 26 sampled residents (9) complained of pain to her left hip. It was later determined (through x-ray) the resident had sustained a left hip fracture but no determination was made as to the cause (an injury of unknown origin). Failure to investigate an injury of unknown origin places residents at risk for continued injuries (unrecognized abuse, unrecognized medical condition and/or unsafe care of residents) and failure to protect residents from harm. Findings: On July 20, 2011, at 7:00 a.m., Resident 9 was observed in her room, lying in bed. She motioned to her leg (s), a certified nursing assistant (CNA) was called to the room and it was determined the resident was complaining of pain to her leg(s).	F 226	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the Director of Nursing immediately re-investigated the incident report, and re-assessed Resident 9. Findings revealed the fracture to left hip showed by X-ray report dated May 22, 2011 was due to Osteoporosis. IDT meeting was conducted on 9/19/2011 and identified resident risks for injury due to multiple complex medical problems. Care plans were reviewed to remain appropriate and updated based on current assessment. Further investigation and re-assessment revealed interdisciplinary team was able to identify cause of injury, and there was no evidence of unsafe care, or to substantiate abuse were noted. **Identification of Areas with Potential for Adverse Effect:** All incident reports filed in the Incident Report Log for 2011 were re-reviewed, and re-investigated by MDS staff and DON to assure that cause of incidents were identified, and that facility complied with the Abuse Prevention policy to assure residents are protected from harm. None of the reports	7/27/2011

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F 226	Continued From page 4 On July 20, 2011, at 10:30 a.m., during an interview, through an interpreter (the activity director), Resident 9 stated she was walking upstairs exercising and she fell. She stated she did not remember who helped her up and did not feel pain until the next day. On July 21, 2011, at 12:15 p.m., during an interview, Registered Nurse 2 (RN 2) stated Resident 9 complained of pain to her left leg and through and interpreter (activity director) she asked her if she had fallen, the resident told her no. On July 21, 2011, at 12:15 p.m., during an interview, the director of nursing (DON) stated because Resident 9 had a diagnosis of osteoporosis they assumed her fracture was a pathological one and therefore no investigation was conducted. During the investigation of complaint #CA00274178, a review of Resident 9's Admission Records indicated she was readmitted to the facility on June 1, 2011, with diagnoses including status post ORIF (open reduction internal fixation) of the left hip, left intertrochanteric (hip) fracture, difficulty in walking, osteoarthritis (arthritis in the joints) and osteoporosis (weak bones). A Licensed Nurse Record, dated May 22, 2011, during the 3:00 p.m., to 11:00 p.m., shift indicated Resident 9 had complaints of pain, 6/10 (10 being worst pain and 1 being mild pain) to her left hip. She was assessed, given pain medication. The physician was called and she was transferred to	F 226	reviewed were affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The Administrator provided in-service on Sept. 21, 2011 to all Department Heads regarding proper process to conduct incident report/Abuse investigation. The DON also provided in-service on Sept. 21, 2011 to all nursing staff regarding Incident Reports investigation to assure completeness of the information and follow the facility Abuse Prevention Policy and reporting protocol. **Monitoring Plan(s):** The DON of her designee will review all incident reports for completeness before documenting the report on the Incident Report Log. Further investigation should be conducted by the DON/her designee to assure that all causes of incident were properly identified and promptly reported. Findings will be reported and discussed at the CQI meeting for compliance.	

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F 226	Continued From page 5 the acute care for evaluation. An x-ray result, dated May 22, 2011, indicated Resident 9 had a basicervical fracture of the left femur with counterclockwise rotation of the femoral head component (left hip fracture). A facility policy on Accidents and Incidents-Investigating and Reporting, revised 2011, indicated the nurse supervisor/charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. A completed report of incident/accident form must be submitted to the director of nursing services no later than twelve hours after the occurrence of the accident or incident. The nurse supervisor/charge nurse and/or the department director or supervisor shall: complete a report of incident/accident form and submit a copy to the director of nursing services within twelve hours of the incident or accident. Submit the original copy of the report of incident/accident form to the administrator no later than twenty-four hours after the occurrence of the accident or incident.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility's nursing staff failed to promote the dignity of 2 of	F 241	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the Charge Nurse responsible for the care of Residents 8 and 12 immediately informed all nursing assistants the proper way of moving residents when up on a shower chair, and the proper procedure to assure resident comfort after giving shower. MDS staff and Social Service staff assessed resident 8 and 12 for possible feelings of embarrassment, discomfort and confusion. Findings	7/21/2011

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F 241	Continued From page 6 26 sampled residents (8, 12). Resident 8, a cognitively impaired resident, was pulled backwards in a shower chair from her room to the shower room and back. Resident 12 was left completely exposed during a bed bath. Failure to cover residents during their bed baths and transport a cognitively impaired resident in a forward position creates the potential for feelings of embarrassment, discomfort and confusion. Findings: a. On July 19, 2011, at 11:45 am, Resident 12 was observed during a bed bath. After removing the resident's gown, Certified Nursing Assistant 1 (CNA 1) did not cover the resident with a towel or bath sheet, but left the resident completely exposed during the entire bath. A review of the medical record indicated Resident 12 was admitted to the facility on October 8, 2010, with diagnoses including history of a stroke, muscle weakness and dementia (loss of intellectual function). A resident care plan, dated April 20, 2011, addressed Resident 12 needing assistance with his activities of daily living. The nursing interventions included dressing and undressing the resident appropriately and providing privacy. The licensed nurses' notes, dated July 20, 2011, indicated Resident 12 was alert and oriented x 2. Resident 12 required limited to extensive assistance with bathing and dressing. On July 19, 2011, at 3 pm, Resident 12 stated the CNA leaves him uncovered all the time when he's	F 241	were documented on resident's individual record, without negative findings noted to both residents. **Identification of Areas with Potential for Adverse Effect:** All CNA's were closely observed by the Director of Staff Development, during provision of shower to all scheduled residents, to assure staff transported resident up on the shower chair in forward position from their respective rooms to the shower room, and residents are covered with a bath blanket after being bathed. None of the residents due for shower were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DSD and RN Supervisor will do daily spot checks of CNA's providing shower to ensure that residents are transported in a forward position and properly covered during and after bath. One-on-one in-service will be provided if shower and bed bath policy is not followed. The Director of Staff Development provided in-service on 9/21/2011 to all nursing staff about the facility policy and procedure on giving a bed bath, and will continue to provide the in-service on giving a bed bath policy and procedure every two months for six months.	

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F 241	Continued From page 7 getting cleaned up, but agreed he probably should cover him up. A facility policy and procedure on "Giving a bed bath" dated 2011, indicated a bath blanket should be used to cover the resident and the resident should remain covered as much as possible. In addition, only one part of the body should be bathed at a time and each part of the resident's body should be covered after being bathed. b. On July 18, 2011, at 8:30 a.m., during the initial tour of the facility, Registered Nurse Supervisor 3 (RN 3) stated Resident 8 was alert but confused, very hard of hearing and visually impaired. On July 19, 2011, at 9:45 a.m., Resident 8 was observed lying in his bed with a fixed stare. When his name was spoken by the Surveyor, he stared at the Surveyor with a confused look. On July 19, 2011, at 10:03 a.m., and 10:50 a.m., Resident 8 was observed sitting in a shower chair being pulled by Certified Nursing Assistant 2 (CNA 2) backwards from his room, down the hallway, to the shower room and back to his room. A review of Resident 8's Admission Records indicated he was admitted to the facility on December 11, 2010. A Minimum Data Set (MDS) Assessment, dated June 23, 2011, indicated Resident 8's cognitive skills for daily decision-making were moderately impaired.	F 241	Monitoring Plan(s): The Director of Nursing/her designee and IDT members will monitor implementation through daily rounds, and obtain information from Resident Council meetings regarding concerns and issues about Dignity and Respect of Individuality. Findings will be reported to CQI meeting to assure compliance.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		

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F 246	Continued From page 8 A resident has the right to reside and receive services in the facility with reasonable 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 observation, interview, and record review, the facility's nursing staff failed to ensure 1 randomly selected resident (RS 28) had a call light that was accessible to her. Failure to ensure residents are able to ask for assistance by having their call light within reach places the resident at risk for lack of care and services. Findings: On July 21, 2011, at 2:50 p.m., RS 28 was observed sitting in a wheelchair on the left side of her bed near the footboard. RS 28 began to yell as though she was trying to get someone's attention (she did not speak English and was not understood by the Surveyor). When asked by the Surveyor, "Do you want your nurse?" RS 28 responded, "Nurse! Nurse!" RS 28's call light was observed on the floor on the right side of the resident's bed wrapped around the upper bed rail. On July 21, 2011, at 3:00 p.m., during an interview, Certified Nursing Assistant 3 (CNA 3) stated she was the nurse who was assigned to RS 28 and had transferred her to her wheelchair earlier. She stated she should have made sure	F 246	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the Charge Nurse and the Director of Staff Development immediately placed the call light of resident 28 within reach, checked its functioning, and that resident knew how to use the call light. Resident 28 was assessed to identify needs via an interpreter. Resident 28 needs were rendered and made resident comfortable and safe. **Identification of Areas with Potential for Adverse Effect:** The Director of Staff Development and Charge Nurses immediately did resident room rounds to assure that all call lights are properly placed, working, and made accessible to resident whenever resident needs to use call light for assistance. None were found affected by alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON/ her designee provided in-service on 9/21/2011 to all facility staff regarding facility policy and procedures on Resident Rights to reside and receive services including use of call light for need or assistance. The DSD will continue to provide this in-service on monthly basis for 3 months.	7.21.2011

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F 246	Continued From page 9 the resident had access to her call light before she left the room. A review of RS 28's Admission Records indicated she was readmitted to the facility on June 21, 2010, with diagnoses including Parkinson's disease (a progressive disorder of the nervous system that affects movement), psychosis (abnormal condition of the mind), and dementia (a serious loss of mental ability).	F 246	**Monitoring Plan(s):** The DON/ her designee will review Resident Council meeting documents to identify concerns regarding prompt attention to resident needs, provision of care, and reports from IDT members' daily room rounds. Findings will be reported and discussed at the CQI meeting to assure compliance.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the housekeeping and maintenance staff failed to ensure residents' equipments and common areas were maintained in a sanitary and orderly manner by having unpleasant odors, dirt/dust/mold build-up, non-functional lights and exhaust fans, missing faucet handles and antiskid tapes on bathroom floors, peeling paints on the ceiling and walls, broken tiles/walls/window screens/door frames/equipments, dirty curtains, unlabeled residents' personal used items, drains filled with debris, loose shower heads and electrical outlet covers, hot water more than 120 degrees Fahrenheit, and janitor closets left unlocked. These deficient practices may create an unsafe environment that may lead to injury (e.g.- skin tears, falls), and attract pests due to unsanitary conditions.	F 253	**Immediate Corrective Action(s):** The facility has taken the following actions: Corrections for July 20, 2011 Findings: 1. Light Cover in the laundry room was replaced — **7.23.2011** 2. An exhaust fan was installed in the public bathroom located in the lobby. — **8.10.2011** 3. Scraped rusty metal off, smoothen sharp edges, repaired and painted door frame of shower room B23 — **8.09.2011** 4. Adjust the hot temp to a lower degree (not to exceed 120° F) — **7.23.2011** 5. Installed new exhaust fan in Shower Room B22 — **9.08.2011** 6. Scraped rusty metal off, smoothen sharp edges, repaired and painted door frame of shower room B22 — **8.09.2011** 7. Removed peeling plastic material and repainted ceiling in Shower Room B22 — **8.09.2011** 8. Cleaned off mildew on wall surface and installed a new exhaust fan in Shower Room B31 — **9.12.2011**	

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F 253	Continued From page 10 Findings: On July 20, 2011 from 8:10 a.m. to 11:00 a.m., during a general observation tour of the facility, in the presence of the maintenance staff and the administrator, the following were observed: 1. There was a missing light cover and cracked light cover in the laundry room. 2. There was a strong odor in the public bathroom located in the lobby. During an interview with a maintenance staff member at the time of observation, he stated there was no exhaust fan. 3. The door frame to Shower Room B23 was in disrepair. The base of the frame was rusted, had holes and had sharp edges. 4. The hot water to Shower Room B23 measured 122 degrees Fahrenheit. A maintenance staff member stated at the time of the observation that the water temperature should not exceed 120 degrees Fahrenheit. 5. The exhaust fan in Shower Room B22 did not work. 6. The door frame to Shower Room B22 was broken and rusted. 7. There was peeling plastic material on the ceiling around the lighting in Shower Room B22. 8. The exhaust fan in Shower Room B31 did not work. There was mildew observed on the wall surface in the shower room.	F 253	9. Maintenance department is in process of replacing anti-skid tape for Shower Room B31 10. Installed a new exhaust fan in the bathroom of Room 308 11. The wall was fixed and repainted 12. Replaced the shower curtain to the shower room by room 309 with a new one. 13. Replace blue material covering linen cart stored in room 310. 14. Maintenance department is in process of replacing anti-skid tape for Shower Room B34 15. Facility replaced the broken GeriChair. 16. Wall surface in room 415 was repaired. 17. Installed new window screen in room 423 18. Shower room B42 ceiling was repainted; shower curtain replaced. Maintenance department is in process of replacing blue cushion on shower chair and installing anti-skid tape for Shower Room B42. 19. Vacuum and cleaned Exhaust fan in the public bathroom, by room 408 20. Installed protective cover to the lighting in the corridor by room 404; also replaced light diffuser. 21. Maintenance department is in process of replacing anti-skid tape for Shower Room B40 22. Maintenance department is in process of replacing anti-skid tape for Shower Room B52 23. Facility replaced gerichair	10.21.2011 8.09.2011 8.09.2011 8.02.2011 10.21.2011 10.21.2011 8.02.2011 8.04.2011 8.04.2011 10.21.2011 9.06.2011 7.22.2011 10.21.2011 10.21.2011 8.02.2011

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056334	A. BUILDING _____ B. WING _____	07/26/2011

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F 253	Continued From page 11 9. There was missing anti-skid tape on the floor in Shower Room B31. 10. There was dust build-up on the exhaust fan in the bathroom of Room 308. 11. The wall was damaged in the shower room by Room 309. The walls also had brown stains and there were broken ceramic wall tiles. 12. The shower curtain to the shower room by Room 309 had brown and yellow stains. 13. The blue material covering the linen cart stored in Room 310 was tattered and had frayed ends. 14. There was missing anti-skid tape on the floor and there was peeling paint on the ceiling to Shower Room B34 by Room 321. 15. There were torn armrests to the Geri-chair stored in the corridor by Room 418. 16. The wall surface in Room 415 was in disrepair. There was a 5-ft horizontal scrape on the wall surface. During an interview with the administrator at the time of the observation, he stated equipments hit the wall which causes the scrapes. 17. There was a torn window screen in Room 423. 18. There was missing anti-skid tape on the floor, peeling purple paint on the ceiling, dirty shower curtain and a torn blue cushion to the shower	F 253	Corrections for July 18, 2011 Findings: 1. Immediately notified housekeeping to clean up the room; and maintenance regrouted the tiles. 2. Foot rest was removed and relocated to a safer area. 3. Air conditioning units in rooms 301, 302, 303, 304, 306, 307, 308, 309, 310, 313, 315, 316, 318, 319, 320, and 321 were cleaned. Vacuum coil, filter and clean housing as a preventive measure 4. Facility Replaced Gerichairs 5. Bed pans and wash basins and urinals were all labeled. 6. Removed peeling paint and re-touch wall paint 7. Shower curtain was replaced. Disinfected and cleaned both walls and floor. Regrout floor tiles 8. Replaced the toilet lid in room room 309 9. Secured wall receptacle cover in rooms 312 and 316 10. Replace lock with the store room door knob. **Identification of Areas with Potential for Adverse Effect:** The Administrator directed all department heads to include the noted deficient items on their weekly round audit; most items that are found deficient are brought up to the stand up meeting for immediate action.	8.09.2011 7.18.2011 7.19.2011 8.02.2011 7.27.2011 7.27.2011 8.09.2011 8.16.2011 7.19.2011 8.24.2011

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F 253	Continued From page 12 chair in Shower Room B42. 19. There was dust build-up to the exhaust fan in the public bathroom by Room 408. 20. There was a missing light protective cover to the lighting in the corridor by Room 404. In addition, one of two lights only works leaving the area dark. 21. There was torn anti-skid tape on the floor of Shower Room B40 by Room 404. 22. There was torn anti-skid tape on the floor of Shower Room B52. 23. There were torn armrests to the Geri-chair stored in the corridor by Room 518. On July 18, 2011, at 8:30 a.m., during the initial tour of the facility and throughout the remainder of the survey the following was observed: 1. The shower room near Room 301 had multiple items of trash and debris in the shower floor drain, such as gloves and plastic covers from the razors. There was mold in the grout of the floor and wall tile. The shower room had dirty/used towels in it, the handle was missing from the faucet, and the shower head was not attached to the wall. There were wash basins on the floor unlabeled. The non slip device that was on the floor was partially missing. 2. A storage room next to Room 301 had wheelchair feet rest on the floor in front of the door.	F 253	**Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The Administrator has developed a tool to include the items, listed as deficiencies, on the room round inspection held by the department heads on a weekly basis. **Monitoring Plan(s):** The Administrator and/or designee will review the room round audit reports weekly; and address all repairs as needed. Findings will be reported and be discussed at the CQI meeting to assure compliance.	

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F 253	Continued From page 13 3. Air conditioning units in Rooms 301, 302, 303, 304, 306, 307, 308, 309, 310, 313, 315, 316, 318, 319, 320, and 321 were observed with dirt, trash debris and/or what appeared to be food debris in the vents. A facility policy on Air Conditioning Systems, dated January 2011, indicated monthly preventive maintenance will include cleaning (vacuum or blow out) facility air intakes and air vents and to clean around system and system itself. 4. Multiple armrests on wheelchairs and Geri chairs were observed cracked, torn and/or with the foam visible or protruding. 5. In Room 303, the bed pan and wash basin were not labeled. In Room 311, the urinal was not labeled. 6. Multiple walls had peeling paint, paint that was missing and/or patched over. 7. The shower room near Room 309 was malodorous, had mold on the floor, the walls were stained and had holes in them and the shower curtain was stained. 8. In Room 309, the toilet lid was off of the toilet and leaning against the wall. 9. In Rooms 312 and 316, the electrical outlet cover was not secured to the wall 10. The janitor closet near Room 317 was left ajar/unlocked. The room had multiple bottles of chemicals inside of it. There was a room next to it, which was also left unlocked with chemicals in	F 253		

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F 253	Continued From page 14 it. A facility policy on Location of Hazardous Chemical, revised 2011, indicated all storage areas are kept locked at all times On July 18, 2011, between 8:30 a.m. and 9:30 a.m., during an interview, Registered Nurse Supervisor 3 (RN 3) stated she would bring the findings to the attention of the appropriate people.	F 253		
F 286 SS=F	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by; Based on interview and record review, the facility's nursing staff failed to ensure all Minimum Data Set (MDS) Assessments were kept in the active records. Failure to ensure the MDS Assessments were accessible to staff places residents at risk for non continuity of care. Findings: a. On July 20, 2011, at 11:22 a.m., during an interview, Registered Nurse Supervisor 3 (RN 3) stated all MDS assessments were kept on the 6th floor in a common area because they had no room for them in the resident's charts and there was no extra storage area for them on the resident floors. A review of Residents 7, 8, 9, 21, and 22's	F 286	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the MDS Coordinator and assessment nurse staff immediately filed the 15 months assessments for the following: a. Residents 7, 8, 9, 21 and 22 on their individual medical records. b. Residents 4, 5, 6, and 19's assessments were filed on their respective medical records available for review. **Identification of Areas with Potential for Adverse Effect:** THE MDS staff gathered all the assessments of residents to provide MDS with individual files in their respective Nursing Stations, for easy access to staff that will assure continuity of care. The Administrator ordered four file cabinets with locks, intended for MDS files only to be stored at four different Nursing Stations. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON provided in-service to MDS staff and medical records staff regarding	7.21.2011 9.22.2011

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F 286	Continued From page 15 medical records indicated there were no MDS Assessments available. A facility policy on Resident Assessment Instrument: Minimum Data Set and Care Plan dated November 2010 indicated each resident's active health record shall include the prior 15 months of all components of the MDS records. b. A review of Residents 4, 5, 6, and 19's medical records indicated there were no MDS Assessments accessible to the surveyors during the recertification survey. During an interview, on July 21, 2011, the MDS nurse stated all the MDS Assessments are kept on the 6th floor in a common area because they had no room for them in the resident's charts or no extra storage area for them on the resident floors.	F 286	the policy and procedures on Resident Assessment Instrument: MDS and Care Plan, to assure that the 15 months assessment of each resident is filed and stored at the respective Nursing Stations for easy access to staff for review. Medical Records staff will audit MDS files on weekly basis to assure completeness of records. Findings of audit will be reported to the DON weekly. **Monitoring Plan(s):** The DON/her designee will review the medical record audit reports weekly, and will randomly check the MDS files for completeness once every two weeks. Findings will be reported and be discussed at the CQI meeting to assure compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to medicate one of twenty six sampled residents (1) prior to a treatment for a Stage IV pressure ulcer (a skin sore that develops due to	F 309	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the RN Supervisor immediately assessed resident 1's pain sensation. Resident 1 was unable to verbally communicate feeling of discomfort due to cognitive impairment. Resident 1's facial expression showed no indication of a feeling of discomfort during the time of assessment. LN 14 administered medication as ordered, and effect of pain meds was evaluated and found effective as evidenced by maintaining resident comfort. LN 13 was immediately provided in-service regarding Five Rights of Medication Administration.	7.21.2011

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F 309	Continued From page 16 unrelieved pressure, Stage IV pressure ulcers have full skin and underlying tissue loss with exposed bone, tendons or muscles). Resident 1 had a physicians order to be medicated thirty minutes prior to treatment (dressing change). The facility staff performed the treatment an hour early and did not ensure the resident had received the pain medication. This deficient practice had the potential of causing Resident 1 to suffer unnecessary pain. Findings: A review of Resident 1's record of admission indicated she was admitted to the facility with diagnoses that included pneumonia, acute respiratory failure, seizure disorder and ventilator (machine that breathes for the resident) dependent. A review of Resident 1's Minimum Data Set (a comprehensive, systematic assessment tool), dated January 18, 2011, indicated she was severely cognitively impaired, totally dependent on staff for all activities of daily living (ADLs), had a Stage IV pressure ulcer measuring 2.5 centimeters (cm.) in length, 1.4 cm. in width, and 0.5 cm in depth. The MDS further indicated Resident 1 was to be on a scheduled pain medication regimen and that within the five days prior to the assessment date, (January 18, 2011), the resident had required non-medication interventions for pain. On July 20, 2011 at 7:30 a.m., Licensed Vocational Nurse 15 (LVN 15) was asked by surveyor to please notify the surveyor when the treatment for Resident 1 was to be done. At 8:30	F 309	**Identification of Areas with Potential for Adverse Effect:** All residents with pressure ulcers receiving pain medications were re-assessed, and Medication Administration Records were reviewed to assure that LN administered pain medications as ordered prior to wound treatment. None were found affected by alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON provided in-service to all Licensed Nurses about the Wound Care Protocol, and the Rights of Medication Administration. RN Supervisor will monitor Treatment Nurse to communicate with LN medication nurse to assure residents with pressure ulcer are administered pain medication as ordered prior to wound treatment on daily basis. **Monitoring Plan(s):** Treatment Nurse will obtain the list of residents with pressure ulcers with order of pain medication prior to treatment. Tx Nurse will then coordinate/ communicate with the Medication Nurse to assure pain medication order will be administered before wound treatment. DON/her designee will observe Tx nurse during wound care to identify LN complies with facility policy on Wound Care protocol. Findings will be reported and be discussed at the CQI meeting for compliance.	

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F 309	Continued From page 17 a.m., when LVN 13 was reminded of the observation, he stated he had already done the treatment on Resident 1's Stage IV pressure ulcer. When asked if the resident had received her pre-treatment medication, LVN 13 said no, he had not notified the medication nurse to give the resident the medication early. LVN 13 further stated the resident does grimace sometimes while the treatment is being done, but she had not done so that morning. On July 20, 2011 at 9:10 a.m., LVN 14 stated she had administered Resident 1's pain medication at 8:30 a.m., in preparation for her treatment at 9 a.m. LVN 14 stated she had not been informed the resident's treatment was to be done at an earlier time. A review of the physician's orders, originally ordered May 23, 2011, and updated on July 2011, indicated Resident 1 was to receive Tylenol 640 mg/20 milliliters every day, thirty minutes prior to wound treatment for pain. A review of Resident 1's plan of care, dated January 18, 2011, and updated on July 2011, identified providing pain medication as one approach the facility would use to manage Resident 1's pain. A review of the facility's undated Pressure Ulcer Treatment policy indicated pain control as one of the five interventions necessary for effective pressure ulcer care.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the RN Supervisor immediately assessed residents 5, 8, and 12 of their physical condition	7.21.2011

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F 312	Continued From page 18 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's staff failed to ensure 3 of 26 residents (5, 8 and 12) received a complete shower, appropriate incontinence care, were provided oral hygiene and had body wash used to clean them rinsed off during a bed bath. Resident 5 was incontinent of feces and the certified nursing assistant (CNA), who was assigned to clean her, neglected to clean her vaginal area, also neglected to clean behind her left stump. Resident 8's mouth was observed with a thick white substance, which was not cleaned. During his shower his back, buttocks, thighs and ears were not cleaned. CNA 1 failed to completely clean Resident 12 during incontinence care, offer or provide oral care and failed to rinse the body wash off during a bed bath. Failure to provide oral care, completely and thoroughly clean a resident during a bed bath/shower and failure to provide incontinence care places residents' at risk for bad breath, oral infection, dry, irritated skin, skin breakdown and body odor. Findings: a1. On July 18, 2011, at 9:20 am, upon entering Resident 12's room, there was a strong odor of stool noted. Resident 12 was lying in bed with a folded draw sheet underneath him, a hospital	F 312	specifically: a. Resident 12's incontinent care of bowel functioning. The CNA assigned to resident 12 was instructed and observed by RN Supervisor, to clean completely, resident buttocks and changed clean pants, and kept resident clean, dry and odor free. CNA properly dressed resident to maintain well-being and dignity, and positioned resident in bed comfortably and safely. CNA 1 was immediately provided an in-service by DSD on ADL care procedures, implementing intervention as planned such as to apply lotion/skin protectant after bath on 7/18/2011. b. Resident 5's incontinent care of bowel functioning. RN Supervisor re-assessed resident's perineal area including behind the left stump to assure resident remains clean, neat and odor-free. CNA 4 was immediately provided in-service and skills competency evaluation on proper procedure in providing perineal care including stump care and proper rinsing residents after bath on 7/20/2011. c. Resident 8's oral hygiene, cleanliness of behind the ear, and back. RN Supervisor immediately assessed resident's overall appearance. CNA 2 was instructed and observed by RN Supervisor during ADL care, to assure resident 8's personal hygiene care including	

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F 312	Continued From page 19 gown on and his pants down around his lower legs. The draw sheet was observed with stool on it, covering an area measuring approximately two to three inches in diameter. As the CNA 1 turned the resident onto his left side, stool was observed smeared on the back upper right side of the diaper and on the resident's skin. CNA 1 was repositioning Resident 12 in order to pull the resident's pants up over the soiled diaper. CNA 1 did not stop until the surveyor intervened and questioned him about the stool on the bed, the diaper and the resident's skin. When Resident 12's diaper was opened, the skin around the perineal area had a yellow-brown color, which was the same color as the stool observed on the diaper and the draw sheet. CNA 1 had to re-clean Resident 12's perineal area and stool was observed on the wash cloth approximately three to four times after wiping the resident. A review of the medical record indicated Resident 12 was admitted to the facility on October 6, 2010, with diagnoses including muscle weakness and clostridium difficile (infectious diarrhea). A resident care plan, dated October 6, 2010, addressed the concern of Resident 12's self care deficit. The nursing interventions included providing the resident with assistance while changing clothes and keeping the resident neat, clean and odor free. According to a urinary and bowel incontinence assessment, dated April 20, 2011, Resident 12 was frequently incontinent of bowel function and used incontinent pads. A resident care plan, dated April 20, 2011,	F 312	good oral care was provided appropriately. Resident 8's mouth was cleaned, all surfaces of the body were washed thoroughly and applied lotion as planned. RN Supervisor and CNA inspected both of resident 8's ears, and kept cleaned. Resident 8 was properly dressed to maintain well-being and dignity. CNA 2 was provided in-service on 7/19/2011 about the facility policy on ADL care. **Identification of Areas with Potential for Adverse Effect:** The RN Supervisor and MDS Coordinator assessed all residents dependent on staff for provision of ADL care. None were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** DSD provided in-service to all CNA regarding facility policy on Provision of ADL care on 7/20/2011, and will continue to provide monthly for 6 months. DSD will perform spot check and observation of CNA skills during provision of ADL care. Findings will be reported to the DON/her designee. Charge Nurses will assess resident physical appearance during change of shift rounds and during medication pass, and will provide ADL care promptly as indicated. Findings will be communicated	

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F 312	Continued From page 20 addressed Resident 12 needing assistance with his activities of daily living. The nursing interventions included providing the resident with clean clothes, thoroughly cleansing the resident after every episode of incontinence and checking the resident frequently for soiling. A review of the licensed nurses notes, dated July 20, 2011, indicated Resident 12 was alert with periods of forgetfulness. Resident 12 required extensive assistance to being totally dependent on the staff with his toileting needs. In addition, the notes revealed Resident 12 was receiving antibiotics (Vancomycin) for his clostridium difficile. On July 18, 2011, at 9:50 am, CNA 1 agreed there was stool on the draw sheet and the resident's diaper. CNA 1 acknowledged that Resident 12 was not completely clean. a2. On July 19, 2011, at 11:45 am, Resident 12 was observed during a bed bath. CNA 1 bathed the resident with Dermarite body wash, however he did not rinse the soap off of the resident's skin. Upon completion of the bed bath, CNA 1 did not offer oral hygiene or apply lotion to the resident's skin. A review of the label on the body wash indicated the soap was to be rinsed off after bathing the resident. A resident care plan, dated October 6, 2010, addressed Resident 12 being at risk for skin breakdown. The nursing interventions included providing the resident with good skin care when giving a bed bath and applying lotions and skin	F 312	through 24 hour report documentation for follow-up and continuity of care. **Monitoring Plan(s):** DON/ her designee will review the DSD report, and will do daily rounds to observe residents' overall appearance to assure that residents maintain their well-being and dignity, appear neat, comfortable, and odor-free. Findings will be reported and discussed at the CQI meetings for compliance.	

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F 312	Continued From page 21 protectant. A review of a facility policy and procedure on "Giving a bed bath" dated 2011, it was indicated soap has a drying effect on the skin and the skin should be rinsed well. b. On July 20, 2011 at 9:09 a.m., CNA 4 was observed providing care to Resident 5. The resident was incontinent of loose/watery stools and when CNA 4 cleaned the resident she cleaned her from the backside. CNA 4 did not do the following, turn the resident on her back to open the resident's legs, clean between the thighs and vaginal area and did not clean behind the resident's left stump. A review of the resident's clinical record disclosed Resident 5 was admitted to the facility on July 13, 2011, with diagnoses that included acute respiratory failure and contracture of the lower left leg joint. The resident was assessed having severe impairment of her cognition and was totally dependent on staff for her care needs. When interviewed on July 20, 2011 at 11:15 a.m., CNA 4 stated she should have opened Resident 5's legs to clean her better and she never thought about cleaning behind the stump. c. On July 19, 2011, at 9:45 a.m. Resident 8 was observed in his room, lying in bed on his back. His mouth was open and thick mucous was observed on the left side of his mouth. On closer inspection of the inside of the resident's mouth a thick white substance was noted to be on the upper palate of the resident's mouth down to his posterior tongue. At 10:03 a.m., Resident 8 was	F 312		

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F 312	Continued From page 22 taken to the shower room and was observed while CNA 2 cleaned Resident 8 during a shower. The resident was cleaned while sitting on a shower chair with a mesh backing. During the shower, CNA 2 did not raise the resident's back from the mesh baking of the shower chair in order to wash his back. She neglected to wash his buttocks, back of his upper thighs, inside and behind his ears. At 10:26 a.m., the resident was taken back to his room prior to drying his lower extremities. He was placed back in bed covered with a facility gown without applying lotion to his body. Resident 8's mouth was left uncleaned and the thick mucous that was noted earlier (9:45 a.m.) was still present in his mouth. On July 19, 2011, at 10:50 a.m., CNA 2 stated she had to leave to help another resident and had completed her morning care with Resident 8. On July 19, 2011, at 10:50 a.m., during an interview, Licensed Vocational Nurse 3 (LVN 3) stated it was the responsibility of the nursing staff to observe if the resident needed suctioning. He stated he did not notice the resident had a thick mucous plug at the back of his throat and no one had reported it to him. On July 20, 2011, at 10:25 a.m., during an interview, CNA 2 acknowledged it was difficult to clean the back of residents who were sitting on shower chairs especially if they were not able to help lift up. She stated she forgot to clean the resident's mouth and should have noticed and reported the mucous to the charge nurse. A review of Resident 8's Admission Records indicated he was admitted to the facility on	F 312		

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F 312	Continued From page 23 December 11, 2010, with diagnoses including cerebrovascular accident (stroke), dysphagia (difficulty swallowing), gastrostomy placement (a tube inserted into the stomach to receive nutrition and medication), and tracheostomy (a surgical opening in the neck to assist with breathing). A Minimum Data Set (MDS) Assessment, dated June 23, 2011, indicated Resident 8's cognitive skills for daily decision-making were moderately impaired and was totally dependent on the nursing staff to complete his activities of daily living (ADLs), such as personal hygiene and bathing. A facility policy on Mouth Care, revised 2011, indicated the purpose is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth.	F 312		
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: Based on observation, interview, and record review, the facility's nursing staff failed to ensure	F 314	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the Treatment Nurse immediately removed the fitted sheet, draw sheet, two chucks, and incontinent brief from the low air loss mattress of Resident 8 to effectively benefit resident from use of low air loss mattress that will aid in wound healing. Resident 8 was provided with a chuck under the buttock for incontinency. Assessment Coordinator immediately called the attention of the responsible party for an IDT meeting and discussed the risk and benefits of using extra linens while resident is on low air loss mattress for wound management and prevention of recurrence of skin breakdown.	7.19.2011

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F 314	Continued From page 24 they used a low air loss mattress effectively (by not using more than one incontinent absorbency product) for 1 of 26 sampled resident's (8), who was admitted to the facility with multiple pressure ulcers, was at risk for recurrence of pressure sores and was prescribed a low air loss mattress. Failure to use a low air loss mattress effectively places the resident at risk for non-healing of current pressure sores and development of new pressure sores. Findings: On July 19, 2011, at 7:02 a.m., Resident 8 was observed in his room sleeping on a low air loss mattress. On top of the mattress was a fitted sheet, a draw sheet, two chucks and the resident had a diaper on. On July 19, 2011, at 10:26 a.m., Resident 8 was transferred back to his room after the completion of his shower. He was placed back in bed on a low air loss mattress, which was covered with a fitted sheet, a draw sheet, two chucks and the resident had a diaper on. On July 19, 2011, at 10:30 a.m., during an interview, Certified Nursing Assistant 2 (CNA 2) stated the family requested the sheets be put on the bed. A review of Resident 8's Admission Records indicated he was admitted to the facility on December 11, 2010. A Care Plan, dated December 12, 2010, indicated Resident 8 was high risk for further development of pressure ulcers related to fragile skin,	F 314	**Identification of Areas with Potential for Adverse Effect:** Treatment Nurse and RN Supervisor assessed all residents on low air loss mattress and inspected the proper use of linens, cotton draw sheet, and incontinent pad or brief. Provision and use of these items may be indicated depending on the weight and size of resident for turning and repositioning to assure resident's maximum benefit of low air loss mattress. None were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** DON provided in-service to Licensed Nurses and CNAs regarding Skin Care and Wound Management Policy and Procedures with emphasis on the use and care of low air loss mattress. Wound Care specialist also provided in-service to all nursing staff to further explain the policy on the low air loss mattress system on 9/22/2011. In-service to all nursing staff on Skin Care and Wound Management will be provided once every 2 months for 6 months. **Monitoring Plan(s):** DON/her designee will perform daily rounds to assess resident proper use of the low air loss mattress, and avoid over padding the mattress which may cause further skin breakdown. Findings will be reported and discussed at the CQI meeting to assure compliance.	9.22.2011

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F 314	Continued From page 25 Incontinence of bowel and bladder, decreased mobility, requires assistance with activities of daily living, impaired cognition, diabetes, requires the head of his bed elevated due to medical necessity causing pressure on the sacral, coccyx, buttocks area, admitted with pressure ulcers on his right medial buttocks, left trochanter (hip) and right heel. A goal established for the resident was to minimize the risk for developing pressure ulcers. Approaches used included assessing the resident using the Braden assessment tool, providing the resident with a pressure relieving device when in bed and using a low air loss mattress. According to the Braden Scale-for Predicting Pressure Sore Risk, dated December 11, 18, 25, 2010, Resident 8 scored 10. A total score of 12 or less represents high risk for developing pressure sores. A facility policy on Low Air Los Therapy, revised 2011, indicated low air therapy mattress systems are provided with a loose fitting cover sheet that the resident may lie on directly. Those top sheets are water resistant and assist in the prevention of friction and shear. An additional linen top sheet is not necessary for these therapy surfaces and may be contraindicated for wound healing. If a resident is incontinent of bowel and/or bladder then the following guidelines should be followed: Incontinent products containing plastic lining should not be used on low air loss surfaces because these products inhibit the effect of low air loss therapy and prevent the exchange of air for moisture control. Care should be taken to avoid plastic lined disposable briefs and pads on low air loss mattresses. The preferred practice	F 314		

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F 314	Continued From page 26 Includes use of a specialized, breathable incontinent pad or brief to absorb incontinency and assist in turning and repositioning if desired. Linens must always be kept to a minimum. In some cases, a single cotton draw sheet along with one breathable incontinent pad or brief may be indicated depending on the weight and size of the resident. Avoid multiple layers of linens under the resident since this may cause bunching and be contraindicated for wound management and prevention. Care should be taken to avoid "double padding". This refers to a resident that is utilizing more than one incontinent absorbency product.	F 314		
F 315 =D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's staff failed to discontinue an indwelling catheter for 1 of 26 sample residents (10). Resident 10 was admitted to the facility with an indwelling catheter for a Stage III pressure ulcer (full thickness skin loss involving damage to or necrosis [tissue death] of subcutaneous tissue	F 315	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the RN Supervisor immediately assessed resident 10 regarding continuous use of foley catheter. MD was notified of findings with an order to d/c foley catheter, and bladder training x 2 days prior to removal of foley catheter. Resident was placed on the bladder training per facility policy on bladder training for resident with foley catheter. Foleycatheter was removed without abnormality noted post removal. Resident voided well. **Identification of Areas with Potential for Adverse Effect:** The DON assessed all residents with foley catheter to assure that its use is indicated to clinical condition, and is properly monitored for potential urinary tract infection, discomfort, and urinary incontinence. None were found affected by the alleged deficient practice.	9.22.2011

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F 315	Continued From page 27 [the third of the three layers of skin] that may extend down to, but not through, underlying fascia [connective tissue that surrounds the muscles]). While in the facility the ulcer healed and staff failed to remove the indwelling catheter. Failure to remove the catheter created the potential for urinary incontinence, discomfort and urinary tract infection. Findings: On July 18, 2011, at 8:30 am, during the initial tour of the facility, Resident 10 was observed with an indwelling catheter in place. The catheter was also observed on July 19, 20, 21 and 22, 2011, during multiple observations conducted throughout each day. A History and Physical, dated April 3, 2011, revealed Resident 10 was previously known to have a urinary tract infection with sepsis (potentially deadly infection of the blood). A review of the medical record indicated Resident 10 was admitted to the facility on April 26, 2011, with diagnoses including renal failure, muscle weakness and Parkinson's disease (a progressive disorder of the nervous system). According to the bowel and bladder incontinence/catheter assessment, dated April 26, 2011, Resident 10 was admitted with an indwelling catheter in place from the hospital. A review of the nursing admission assessment, dated April 26, 2011, revealed Resident 10 had a Stage III pressure ulcer to the coccyx area (lower back) upon admission.	F 315	**Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON provided in-service to all Licensed Nurses regarding proper assesement of resident using foley catheter per facility policy and procedures on Care of Foley Catheter. MDS staff will include assessment of indication of foley catheter use and will be presented to the IDT meeting to discuss risks and benefits of foley catheter use. MD and responsible party of resident will be informed of findings and plan of care. **Monitoring Plan(s):** The DON/her designee will perform record review of resident with foley catheter weekly to assure the necessary use of foley catheter, and to monitor for any potential complications related to use of foley catheter. Findings will be reported and discussed at the CQI meeting to assure compliance.	

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F 316	Continued From page 28 A resident care plan, dated April 26, 2011, addressed Resident 10 requiring assistance with his activities of daily living. The goal was for Resident 10 to attain the highest functional mobility with his ADLs daily. The nursing interventions included assisting the resident with his toileting needs and encouraging independent functions. A physicians order, dated June 26, 2011, indicated Resident 10's coccyx pressure ulcer had resolved and treatment was to be discontinued. On July 20, 2011, at 2:35 pm, Registered Nurse Supervisor 1 (RN 1) stated Resident 10 had the indwelling catheter for wound management, but was not sure why it was still in place. On July 20, 2011, at 2:55 pm, Licensed Vocational Nurse 1 (LVN 1) agreed the indwelling catheter should have been removed since Resident 10's wound had healed.	F 316		
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:	F 323	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the LVN in charge of resident care together with the RN Supervisor immediately assessed resident's breathing status, including inspection of the mouth and throat. LVN placed the resident on low fowler's position then suctioned the secretion to clear resident's throat. LVN continuously observed resident breathing after the procedure. Resident remained comfortable and noisy breathing got resolved. Head of resident's bed is kept elevated as ordered.	9.22.2011

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F 323	Continued From page 29 Based on observation, interview, and record review, the facility's nursing staff failed to ensure 1 of 26 sampled residents (8), a dysphagic (difficulty swallowing) resident with a gastrostomy tube (a tube surgically inserted in the stomach by which nutrition and/or medications are administered), who had orders to suction secretions as needed for congestion and to keep the head of his bed elevated at a 30 degree angle, was properly positioned and suctioned to prevent aspiration. Failure to maintain safe positioning of a resident and to suction as needed places the resident at risk for aspiration (chocking). Findings: On July 19, 2011, at 9:45 a.m., Resident 8 was observed in his room, lying in bed on his back. The resident was awake, his mouth was open and be was making a gurgling sound. Upon further inspection, a thick white mucous plug was observed in the back of the resident's throat. On July 19, 2011, at 9:56 a.m., Resident 8 was transferred from his bed to a shower chair and was taken to the shower room in a slumped down position. Throughout the shower, during transportation back to his room, after being transferred back to his bed and during the remainder of his morning care, the thick white mucous plug remained at the back of the resident's throat and he could be heard making a gurgling noise. Certified Nursing Assistant 2 (CNA 2) was asked what the noise was. She replied, "What noise?" On July 19, 2011, at 10:50 a.m., during an	F 323	**Identification of Areas with Potential for Adverse Effect:** The RN Supervisor assessed all tracheostomy residents and other residents with gastrostomy tubes of their positioning, oral care and breathing pattern. RN Supervisor reviewed resident's physician's order on keeping head of bed elevated, and suctioning order. RN Supervisor and LVN checked residents on respective position as ordered, and suctioning secretion as indicated. None were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON provided in-service to all nursing staff regarding the facility policy on the Care of Resident with Tracheostomy and Gastrostomy, and will continue the in-service on this area every two months for six months. The DON/her designee will perform daily rounds to assure the staff implement the plan of care and follow the facility policy of providing proper care to residents with tubings. **Monitoring Plan(s):** The DON/her designee will report findings to the CQI meeting to assure compliance.	

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F 323	Continued From page 30 interview, Licensed Vocational Nurse 3 (LVN 3) stated it was the responsibility of the nursing staff to observe if the resident needed suctioning. He stated he did not notice the resident had a thick mucous plug at the back of his throat and no one had reported it to him. A review of Resident 8's Admission Records indicated he was admitted to the facility on December 11, 2010, with diagnoses including dysphagia, gastrostomy placement and a tracheostomy (a tube surgically inserted in the throat to assist with breathing). A Minimum Data Set (MDS) Assessment, dated June 23, 2011, indicated Resident 8's cognitive skills for daily decision-making were moderately impaired. He suffered from shortness of breath or trouble breathing when lying flat and was totally dependent on the nursing staff for bed mobility, transfers, personal hygiene and bathing. Physician's Orders indicated the following: December 11, 2010 - Elevate HOB (head of bed) at least 30 degrees at all times during feeding. May 25, 2011 - Suction as needed for congestion.	F 323		
F 328 SS=D	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;	F 328	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the RN Supervisor and Charge Nurse immediately assessed resident 8's respiratory functioning. Assessment indicated resident oxygen saturation at 98% at room air, breathing unlabored and normal, and skin color pinkish, warm, and dry to touch. Findings were reported to the physician with an order on 7/20/2011 to continue O2 inhalation as needed for SOB.	7.22.2011

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F 328	Continued From page 31 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to ensure 1 of 26 sampled residents (8), who was observed being administered oxygen continuously, had indications for the use of the oxygen and/or orders for its administration. Failure to ensure residents using oxygen had indications and orders for its use places those residents at risk for non continuity of care, unnecessary administration of a medication (oxygen) with adverse effects of oxygen use and unrecognized respiratory conditions. Findings: On July 18, 2011, at 9:45 a.m., during the initial tour of the facility, July 19-25, 2011, all day, Resident 8 was observed with a nasal cannula in his nose receiving oxygen at 2.5 liters per minute (lpm). Observation of the resident showed no shortness of breath, wheezing or other respiratory problems. On July 20, 2011, at 9:21 a.m., during an interview and after observing the resident and reviewing his medical records, Licensed Vocational Nurse 4(LVN 4) stated Resident 8's oxygen saturation levels (a measurement of how much oxygen is being carried by the blood) were usually between 96 and 98 percent (normal range greater than 95%) on and off of oxygen. She	F 328	**Responsible party was notified of findings and MD's order on 7/20/2011. Responsible party was invited to attend IDT meeting held on 7/22/2011 to discuss risk vs. benefits of appropriate use of oxygen. When oxygen inhalation was removed, resident 8 did not show any signs of respiratory distress, and continued monitoring in place for prompt intervention as indicated.** **Identification of Areas with Potential for Adverse Effect:** RN Supervisor and MDS Coordinator assessed all residents on oxygen inhalation, and checked individual resident's physician's orders for indication of oxygen use, and its appropriateness of oxygen administration. None were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON provided in-service to all nursing staff on 7/20/2011 regarding the facility policy on the care of residents using oxygen inhalation. Charge nurses will continue to assess resident's need for continuous use of oxygen and findings will be documented at the Nurses Notes and on the Weekly LN Progress notes. MDS staff to include the information to be discussed at the IDT meeting including the risks and benefits, and will document at the IDT meeting notes to assure resident will be provided necessary care for respiratory	

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F 328	Continued From page 32 stated she had not noticed any respiratory distress, shortness of breath or wheezing and it was usually the family who requested the oxygen be kept on. On July 26, 2011, at 12:00 p.m., during an interview, Registered Nurse Supervisor 3 (RN 3) stated the family most likely wants the oxygen kept on the resident. A review of Resident 8's Admission Records indicated he was admitted to the facility on December 11, 2011, with diagnoses including cerebrovascular accident (stroke), atrial fibrillation (irregular heart rhythm), seizure disorder, dysphagia (difficulty swallowing), tracheostomy (a tube surgically inserted in the throat to assist with breathing), congestive heart failure, and myocardial infarction (heart attack), Physician's Orders, dated December 11, 2010, indicated Resident 8 was to have oxygen administered at 2 liters per minute (lpm) via a nasal cannula as needed for shortness of breath and wheezing. Check oxygen saturation every shift and as needed. A review of Resident 8's Medication Sheet, dated July 2011, indicated oxygen saturation levels ranged from 96% to 98%. A facility policy on Oxygen Administration, revised 2011, indicated to verify that there is a physician's order for the procedure. Review the physician's orders or facility protocol for oxygen administration.	F 328	functioning. Medical Records staff will collect the LN Progress Notes to be reviewed by DON/her designee before filing on the resident medical record. **Monitoring Plan(s):** The DON/her designee will review the LN Weekly Progress notes for the accuracy of assessment to assure resident will not be provided unnecessary administration of oxygen and will prevent adverse effects of oxygen use and unrecognized respiratory conditions. Findings will be reported and discussed at the CQI meeting for compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 33 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to store, prepare, distribute and serve food under sanitary conditions by having an improper sanitizer level in a sanitizer bucket, grime build-up on the wall and floor surface, old rodent droppings, unapproved and poorly maintained equipment, and personal refrigerators in residents' rooms, whose temperatures were not monitored and were above the regulated 41 degrees Fahrenheit. Unsanitary conditions in the kitchen and high refrigerator temperatures may lead to contaminated/spoiled food, pests and foodborne illness. Findings: a. On July 20, 2011, at 11:35 a.m. during a kitchen observation, in the presence of the maintenance supervisor, administrator, and dietary supervisor the following were observed: 1. The test strip sanitizer read "0" ppm (parts per million) when the quaternary ammonia (QT-10)	F 371	**Immediate Corrective Action(s):** Corrections for July 20, 2011 findings: 1. A. In-serviced the dietary staff regarding the proper use of sanitizer buckets and develop a new daily log of time and the test strip sanitizer read (PPM) and internal change of buckets as necessary. 2. Cleaned grime and dirt build-up on the wall and floor surface; Dietary staff was assigned extra cleaning schedule to prevent issue from recurring. 3. Cleaned electrical panel and will continue to monitor and clean panels on a weekly basis. 4. Removed wooden block and replaced it with a concrete block 5. Cleaned stains from ceiling 6. Replaced Light Bulb 7. Repaired the pipe to allow 1-inch air gap from the waste water pipe to the top of the floor sink of the coffee dispenser machine. 8. Cleaned and removed grime from the juice dispenser machine. 9. Maintenance department will reroute the pipe so that it will not be connected to the sewer line. 10. Maintenance department will be replacing the window screen.	7.22.2011

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F 371	Continued From page 34 sanitizer strips were used to test a sanitizer bucket by the food prep sink. 2. There was grime and dirt build-up on the wall and floor surface behind a table near the reach-in coolers. 3. There were 5 to 10 old rodent droppings in the electrical panel closet. 4. There were wood blocks used to support the ice machine leg stands. 5. There were brown stains on the ceiling in the dry food storage room. 6. There was an overhead light fixture that was not working in the dry food storage room. 7. There was no 1-inch air gap from the waste water pipe to the top of the floor sink of the coffee dispenser machine. 8. There was grime build-up inside the nozzle of the juice dispenser machine. 9. The food preparation sink was directly connected to the sewer line. 10. There was a missing window screen to the window near the ice machine. b. On July 18, 2011, at 8:30 a.m., during the initial tour of the facility, the following was observed: 1. The temperature of the refrigerator in Room 303 Bed A was 60 degrees Fahrenheit. The refrigerator had food items in it and was	F 371	Corrections for July 18, 2011 findings: 1. Decreased the cooling temp of 303A refrigerator and monitor temp to meet required temperature. 2. Decreased the cooling temp of 308B refrigerator and monitor temp to meet required temperature. 3. Provided a thermostat for 309B refrigerator. 4. Decreased the cooling temp of 320C refrigerator and monitor temp to meet required temperature 5. Decreased the cooling temp of 321C refrigerator and monitor temp to meet required temperature ROOM 303A ROOM 308B ROOM 309A ROOM 320C ROOM 321C In-serviced nursing staff to reemphasize the importance of following facility policy & procedures with regards to refrigerator and freezer temperatures and proper food storage. Temperatures must be monitored by daily tracking. **Identification of Areas with Potential for Adverse Effect:** Infection Control nurse audited all other resident refrigerators temperature tracking logs to identify that no other refrigerators/freezer temperatures were found to be deficient.	

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F 371	Continued From page 35 malodorous. 2. The temperature of the refrigerator in Room 308 Bed B was 55 degrees Fahrenheit. 3. The temperature of the refrigerator in Room 309 Bed A had no thermometer in it. The refrigerator contained food that appeared to be old. 4. The temperature of the refrigerator in Room 320 Bed C was 50 degrees Fahrenheit. 5. The temperature of the refrigerator in Room 321 Bed C was 50 degrees Fahrenheit. On July 18, 2011, at 8:30 a.m., Registered Nurse Supervisor 3 (RN 3) stated the nurses on the night shift were responsible for checking the residents' refrigerators and logging their temperatures. On July 18, 2011, a review of the Refrigerator Temperature Log for July 2011 indicated the following: Room 303 Bed A - No temperatures listed for July 9-12, 15-18, 2011. The temperature of the refrigerator on July 14, 2011, was 50 degrees Fahrenheit. This was the last day the temperature was taken. Room 308 Bed B - No temperatures list for July 9-12, 15-18, 2011. The temperature of the refrigerator on July 14, 2011, was 49 degrees Fahrenheit. This was the last day the temperature was taken.	F 371	**Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** Dietary department added cleaning hours to the kitchen. The DSD provided in-service to all nursing staff on 7/22/2011 regarding the facility policy on refrigerator and freezer temperatures and proper storage of resident food. **Monitoring Plan(s):** Registered Dietician will audit monthly sanitation in the kitchen to prevent deficiencies from reoccurring. Infection Control nurse will continuously audit temperature logs on a weekly basis. Findings will be reported and be discussed at the CQI for compliance.	

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F 371	Continued From page 36 There was no temperature log for Room 309 Bed A. The temperature log for Room 320 Bed C indicated the temperature for July 18, 2011, was 40 degrees Fahrenheit, although when observed by the Surveyor and RN 3 it was 50 degrees Fahrenheit. There was no temperature log for Room 321 Bed C. A facility policy on Refrigerator and Freezers, revised 2011, indicated the facility will ensure safe refrigerator temperatures. Acceptable temperatures should be 35 degrees Fahrenheit to 40 degrees Fahrenheit. Monthly tracking sheets for all refrigerators will be posted to record temperatures. Monthly tracking sheets will include time, temperature, initials, and "action taken." Food service supervisors or designated employees will check and record refrigerator temperatures daily with first opening and at closing in the evening. The supervisor will take immediate action if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet, including the repair personnel and/or department contacted.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the RN Supervisor and LVN immediately assessed resident 19's condition for potential adverse effect of Phos Nak diluted in less amount of fluid administration via GT. The LVN instructed to immediately flush 240cc water via GT post administration of Phos Nak, and	7.22.2011

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F 425	Continued From page 37 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 and record review, the facility's nursing staff failed to correctly mix a medication prior to administering it to 1 of 26 sample residents (10). According to the package of Phos Nak, the powder was to be mixed with 8 ounces of water prior to administration. Licensed Vocational Nurse 2 (LVN 2) poured the powder into a small cup and added 30 milliliter (ml) of water prior to administering the medication to the resident. Findings: On July 22, 2011, at approximately 9 am, the medication nurse was observed administering medication to Resident 10 via gastrostomy tube (surgical placement of a feeding tube through the abdominal wall, directly into the stomach). LVN 2 mixed the Phos Nak powder into a small medication cup and added 30 ml of water. The	F 425	monitor resident for any abnormality. Resident 10's condition remained stable. Reported incident to MD on 7/22/2011 without new order given. Correct amount of fluid to mix with Phos Nak powder was documented at the Medication Administration Record to provide accurate dispensing and administration of Phos Nak powder. **Identification of Areas with Potential for Adverse Effect:** The DON reviewed all medication orders to identify other residents are receiving the same medication, and that none were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The pharmacy nurse consultant provided an in-service to all Licensed Nurses on 9/23/2011 regarding the pharmaceutical services policy with emphasis on accurate acquiring, receiving, dispensing and administering of all drugs and biological. RN Supervisor will review the physician's orders upon resident admission to the facility to identify medications that require specific instruction to assure accuracy of medication administration. RN Supervisor will follow-up the monthly drug regimen review recommendation upon receipt of the report to assure resident receives safe and appropriate pharmaceutical services.	9.23.2011

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F 425	Continued From page 38 instructions indicated the medication was to be mixed with 8 ounces (237 ml) of water prior to administration however, this was not done. According to Drug 3K, and Healthquare.com Phos Nak is used when the diet does not provide enough Phosphorus, a natural body mineral. The instructions for use of the product indicated to mix the powder with 75 ml of water or juice and follow with a full 240 ml (8 oz) of water.	F 425	**Monitoring Plan(s):** The DON/her designee will review the implementation of the RN Supervisor's findings from admission, physician's order review, and review the monthly drug regimen review recommendation ensuring it was acted upon on a timely manner, as well as to communicate findings to designated staff. The DON/her designee will communicate with the pharmacist to send instructions with the medication during delivery of medications to the facility as indicated. Findings will be reported and be discussed at the COI for compliance.	
F 441 SS=D	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.	F 441	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice: a. Resident 12 was immediately assessed by the RN Supervisor for potential effect of contamination. Resident is neat, clean and odor-free. Vital signs were taken with no abnormality noted. CNA 1 was immediately in-serviced by the DSD regarding facility policy on hand washing and proper use and disposal of personal protective equipment such as gloves. b. Resident 8 was immediately assessed for potential risk of contamination. Resident's vital signs and skin condition showed no abnormal changes. CNA 2 was immediately provided an in-service by the DSD regarding the facility policy on infection control with emphasis on proper handling of soiled linen.	9.23.2011

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F 441	Continued From page 39 (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 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's nursing staff failed to maintain infection control practices for 2 of 26 sampled residents (8, 12) by not removing soiled gloves and washing their hands before acquiring linen from a clean cart and by not transporting soiled linen away from the body. Certified Nursing Assistant 1 (CNA 1) went to the clean linen cart wearing the same gloves he had on while providing incontinence care to Resident 12. CNA 2 held against her clothing soiled linen removed from Resident 8's bed as she carried it to the hamper. Resident 8 had previously been diagnosed with scabies and had raised bumps over his torso and flank. Failure to remove and/or change dirty gloves and to transport soiled linen away from the body created the potential for contamination and the spread of infection. Findings: a. On July 18, 2011 at 9:20 am, CNA 1 was observed providing incontinence care to Resident 12. CNA 1 put on a pair of gloves, helped	F 441	**Identification of Areas with Potential DSD, RN Supervisors and Charge Nurses observed all CNAs during provision of care and handling of soiled linen. None were found affected by alleged deficient practice.** **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DSD provided an in-service to all facility staff about facility policy on infection control with an emphasis on hand washing, proper use of gloves, and handling of soiled linen. The DSD will continue to provide this in-service monthly for 3 months. The DSD and RN Supervisors will monitor staff implementation of infection control practices on daily basis. DSD will develop skill competency and schedule CNA a hand washing, and use of PPE skills demonstration two times per years. Findings will be reported to the DON. **Monitoring Plan(s):** The DON/her designee will review the RN Supervisor's and DSD's reports regarding implementation of infection control practices. Findings will be reported and discussed at the CQI meeting for compliance.	

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F 441	Continued From page 40 reposition the resident and removed the resident's diaper which had stool on it. CNA 1 then grabbed a dry, dirty towel from the resident's night stand and started to clean the resident until the surveyor intervened. CNA 1 then went to the clean linen cart and gathered a few wash cloths while wearing the same dirty gloves. On July 18, 2011, at 9:50 am, CNA 1 agreed he should have removed the dirty gloves before grabbing the clean linen. b. On July 19, 2011, at 9:45 a.m., Resident 8 was observed in his room, lying in bed. His skin (left flank, left trunk, upper left thigh near groin) had multiple raised reddened bumps (back, upper and lower extremities) and had multiple darker bumps. On July 19, 2011, at 9:45 a.m., Resident 8 was transferred from his bed, using a sling, to a shower chair in preparation for his shower. The sling was taken from the resident after he was transferred to the shower chair and was noted to be covered on the edge with loose feces. CNA 2 then took the sheets off of the resident's bed and put them in a dirty linen hamper outside of resident's room. The soiled linen was held against CNA 2's clothing as she carried it to the hamper. On July 19, 2011, at 10:26 a.m., CNA 2 carried the soiled sling against her clothing and then proceeded to use it to transfer Resident 8 back to his bed. A review Resident 8's Admission Records indicated he was admitted to the facility on	F 441		

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F 441	Continued From page 41 December 11, 2010. According to a Dermatology Report, dated March 29, 2011, Resident 8 was positive for scabies following a skin scraping. A facility policy on Soiled Linen, revised 2011, indicated soiled linen shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain mechanical equipments in safe operating condition by having a leaking air conditioner unit and boiler units on the roof, and by having a poorly maintained ice machine. Equipments that leak and create puddles of standing waters may attract pests and vectors that may carry diseases. Findings: On July 20, 2011, from 8:10 a.m. to 11:15 a.m., during a general observation tour of the facility, in the presence of the maintenance supervisor, the following were observed: 1. There was water leaking from a 4-inch black	F 456	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice: 1. Leak taken care of by installing drain pipe directly to drain sewer. — 9.08.2011 2. Hired outside plumbing company to replace leaking flow switch from the boiler. — 7.20.2011 3. Properly maintained and cleaned the ice machine according to manufacturer's recommendation on maintenance and cleaning of the ice machines — 7.21.2011 **Identification of Areas with Potential** Maintenance staff inspected all other areas for noted deficiency. No other areas found affected by alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** — 9.28.2011 The Environmental Supervisor in-serviced maintenance staff on proper cleaning and maintenance of the ice machines according to manufacturer's	

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	056334	A. BUILDING _____ B. WING _____	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSTAR REHABILITATION & NSG CTR OF SANTA MONICA	1340 15TH STREET SANTA MONICA, CA 90404

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F 456	Continued From page 42 plastic pipe in the wall and there was a pool of water in the parking garage by the trash dumpsters. There were also 10 to 15 gnats observed around the area. During an interview with Maintenance Staff 1 at the time of the observation, he stated the water was from air conditioner Unit 7 that was leaking from the roof. 2. There was standing water on the flat roof top from two leaking boiler units. 3. The air filters to the ice machine located in the dining room, on the second floor, had a build-up of dust and lint. In addition, there was grime build-up at the tip to the water nozzle dispenser. According to a sign posted on the ice machine, indicated that the air filters shall be cleaned twice a month. At the time of the observation, the maintenance supervisor stated he could not provide any evidence that the filters were cleaned twice a month, and he could not provide a policy and procedure (based on the manufacturer's recommendations) on maintenance and cleaning of the ice machines.	F 456	recommendation. Staff was also in-servised on routine inspections of equipment leakage and required staff to report any damages to the Environmental Supervisor for proper repairs **Monitoring Plan(s):** A tracking tool was developed to remind maintenance staff of the equipments that needs to be inspected, maintained and cleaned. Findings will be reported and discussed at the CQI meeting for compliance.	
F 463 SS=E	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 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that nurses' stations were equipped to receive resident calls through a	F 463	**Immediate Corrective Action(s):** The facility has taken the following actions to correct the noted deficiency: 1. Repaired call light system for room 514 2. Repaired call light system for room 523B 3. Repaired call light system for room 421A 4. Repaired call light system for shower room B22 5. Corrected call light system for shower room B24	7.18.2011

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F 463	Continued From page 43 communication system from resident rooms and bathing facilities by either the lights not illuminating when the call button was pressed or the call light not properly identifying the correct area at the call light board at the nurses station. A call light system that does not function properly may cause delay or neglect to residents that may need assistance immediately that may result in injury. Findings: On July 18, 19, and 20, 2011, during an initial tour and general observation tour, in the presence of the maintenance staff, the call light system observed not working properly in the following areas: 1. On July 18, 2011 at 9 a.m., the call light to Room 514 did not activate at the panel at the nurses' station when the button was pushed and instead, the light for Room 515 activated at the panel. 2. On July 18, 2011 at 9 a.m., the call light failed to activate to Room 523B when the button was pushed. There was no visual and audible indicator at the nurses' station call light panel. 3. On July 19, 2011 at 9:10 a.m., the call light to Room 421A failed to activate when the button was pushed. There was no visual and audible indicator at the nurses' station call light panel. 4. The call light to Shower Room B22 failed to activate at the panel at the nurses' station on the second floor.	F 463	6. Corrected call light system for shower room B23 7. Corrected call light system for shower room B25 8. Repaired call light system for shower room B31 9. Corrected call light system for shower room B32 10. Replace Light bulb for call light above B33 11. Repaired call light systems for Rooms 408, 410, 422 and 423 12. Repaired call light system for room 408 13. Repaired call light system for shower room B52 14. Replace Light bulb for call light above B55 15. Replace Light bulb for call light above room 527 **Identification of Areas with Potential** Maintenance staff inspected and repaired all other areas for noted deficiency. No other areas found affected by alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** Call lights will be routinely inspected on a monthly basis and/or as needed and will be repaired as needed. **Monitoring Plan(s):** A tracking tool was developed to monitor that call lights are in proper working order and repairs/maintenance are done in a timely manner. Findings will be reported and discussed at the CQI meeting for compliance	

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F 463	Continued From page 44 5. When the call light to Shower Room B24 was activated, the light labeled "B3" activated at the panel instead of B24. 6. When the call light to Shower Room B23 was activated, the light labeled "B25" activated at the panel instead of B23. 7. When the call light to Shower Room B25 was activated, the light labeled "B24" activated at the panel instead of B25. 8. The call light to Shower Room B31 failed to activate at the nurses station panel. 9. When the call light to Shower Room B32 was activated, the light labeled "B31" activated at the panel instead of B32. 10. The call light above Shower Room B33 failed to illuminate when the call button was activated. 11. The call lights above Rooms 408, 410, 422 and 423 failed to illuminate when the call buttons were activated. 12. The call light above Room 408 was dim when the call button was activated. The light could not be seen down the corridor. 13. The call light to Shower Room B52 failed to activate at the panel at the nurses station on the 5th floor. 14. The call light above Shower Room B55 failed to illuminate when the call button was activated. 15. The call light above Room 527 failed to	F 463		

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F 463	Continued From page 45 illuminate when the call button was activated. During an interview with the maintenance supervisor at the time of the observation, he stated he could not explain why the call light system was not working properly. He also stated he does not test the call lights on a routine basis.	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, sanitary, and comfortable environment for residents, staff and the public by storing cast-offs on the ground surface, not securing refrigerators in residents' rooms, allowing a pool of standing water on the ground surface by the trash dumpsters, and allowing lint debris from the commercial dryers to accumulate. Improper storage of cast-off materials on the ground surface may lead to rodent harborage and potentially create a fire hazard. Improper removal of lint debris from the commercial dryers may cause unsanitary conditions and the potential for a fire. A pool of standing water and uncovered trash dumpsters may attract vectors and pests that may carry or transmit vector borne diseases. Refrigerators that are not properly secured in residents' room may pose an accident hazard in the event of an earthquake and may lead to injury. In the event of a sewage back-up, a sink	F 465	**Immediate Corrective Action(s):** The facility has taken the following actions to correct the noted deficiency: 1. Dryer filters were cleaned. In-serviced laundry staff, lint filters need to be cleaned every two hours and documented on a tracking log. — **7.20.2011** 2. Properly secured refrigerators in rooms 314A, 417B, 418B, 426B, and 427A — **7.21.2011** 3. Bin covers put back in place. Contacted City of Santa Monica to repair trash dumpster that was missing a cover. — **7.20.2011** 4. Disposed old equipment and wood remnants. — **8.12.2011** 5. Waiting on management decision for further directions on repair. — **10.26.2011** **Identification of Areas with Potential** Environmental staff inspected and all other areas for noted deficiency. No other areas found affected by alleged deficient practice.	

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F 465	Continued From page 46 faucet without a backflow device may potentially create a cross contamination to the potable water system if a hose was connected to the faucet and stored in the sink. Findings: On July 20, 2011, from 8:10 a.m. to 11:15 a.m., during a general observation tour of the facility, the surveyor, in the presence of the maintenance supervisor, observed the following areas not maintained in a safe and sanitary manner: 1. At 8:15 a.m., the lint filters and bottom inside surfaces in four of four commercial gas-fueled dryers were full of lint. During an interview with the laundry staff member who was responsible for cleaning the lint filters at the time of the observation, she stated she did not clean the lint because she was too busy. In addition, there was no documentation that the filters were cleaned on a routine basis. 2. The refrigerators in Rooms 314A, 417B, 418B, 426B, 427A were not secured. 3. There were four of five trash dumpsters that were uncovered in the parking garage. There was a strong odor and 10 to 15 flies were observed in the area. In addition, a trash dumpster was missing a cover and was overflowing with trash. 4. There were cast-offs stored on the ground located in the south parking garage. There was an accumulation of plywood, old equipments and supplies stored on the ground. 5. There was no backflow device on the faucet to	F 465	**Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** In-serviced Environmental staff on safe/functional/sanitary and comfortable environment. Director of Environmetal Services will be conducting random inspections to prevent reoccurrence of noted deficiencies. **Monitoring Plan(s):** A tracking tool was developed to monitor that the facility has a safe, functional, sanitary and comfortable environment. All deficient practices found will be addressed in a timely manner. Findings will be reported and discussed at the CQI meeting for compliance.	

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F 465	Continued From page 47 the janitorial sink by Room 417. There was a hose directly connected to the end of the faucet and was stored inside the sink.	F 465		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to firmly secure handrails to the corridor wall. Handrails that are not firmly secured to the wall may create an accident hazard by having a resident, who needs assistance with ambulation and or balance, fall to the floor that may result in injury. Findings: On July 20, 2011, from 8:10 a.m. to 11:15 a.m., during a general observation tour of the facility, in the presence of the maintenance supervisor, the handrail located on the corridor wall by Room 305 was not secured. When pressure was applied to the handrail, the handrail pushed into the wall. During an interview with the maintenance supervisor at the time of the observation, he could not explain why the handrail was not secured to the wall.	F 468	**Immediate Corrective Action(s):** Maintenance staff properly secured the handrails to the wall **Identification of Areas with Potential** Environmental staff inspected all other areas for noted deficiency. No other areas found affected by alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** Environmental Staff will conduct a routine inspection of the handrails to ensure that all handrails are properly secured to the wall **Monitoring Plan(s):** A tracking tool was developed to monitor that the facility handrails are firmly secured to the wall. Findings will be reported and discussed at the CQI meeting for compliance.	7.20.2011
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514	**Immediate Corrective Action(s):** Upon verbal notification of alleged deficient practice, the RN Supervisor immediately assessed:	7.27.2011

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F 514	Continued From page 48 resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's nursing staff failed to ensure records for five of 26 sampled residents (8, 9, 13, 21, and 24) and one randomly selected (RS 28) were complete and placed in the resident's medical record. Resident 13 had consultations with an outside physician and returned from the appointments without documentation regarding the care and services, placing the resident at risk for delay in treatment and non-continuity of care. Residents 8, 9, 13, 21, 24, and RS 28 had consent forms for physical and/or chemical restraints without signatures and/or dates the physician signed the consents. Failure to comply with regulations regarding informed consents places residents at risk for receiving unnecessary/unauthorized services. Findings: a1. On July 18, 2011, a review of the medical record indicated Resident 13 was admitted to the facility on August 5, 2010, with diagnoses	F 514	a1. Resident 13 attending physician were notified of missing consult report as follows: hematology consult, neurology consults, cardiology consult and dermatolofy consult. Charge Nurse immediately contacted the consultation offices to obtain report from the said consults. Resident 13 condition was assessed to determine the need for these consults. IDT meeting held and discussed resident 13's need to be seen by these consults. MD reassessed resident medical condition. a2. Medical Records staff immediately obtained MD signature for padded side rail use, use of Ativan and use of Doxepin for Dx of anxiety informed consent and dated. b. The RN Supervisor revised resident 8, informed consent for using left hand mitten to prevent pulling tracheostomy, and then attending physician and facility representative signed and dated consent on 7/26/2011. c. The RN Supervisor revised resident 9's informed consent for using the side rails, use of Ambien, Effexor, and Seroquel, indicating the diagnosis for its use was signed by attending physician and facility representative including the staff. Signature was obtained and dated accordingly.	

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F 514	Continued From page 49 including anoxic brain syndrome (no oxygen to the brain cells), dysphagia (difficulty swallowing) and gastrostomy tube (a tube surgically inserted in the stomach for feeding). Review of Resident 13's medical record disclosed a physician's order on April 19, 2011, for a hematology consultation, a neurology consultation on April 23, 2011, a cardiology consultation on April 17, 2011, and a dermatology consultation to be done. There was no documentation of the care and services provided by any of the consulting physicians in the medical record. On July 25, 2011 at 11:30 a.m., during an interview, Licensed Vocational Nurse 5 (LVN 5) stated the nurses send a blank progress note with the resident for the physician to document the care and services provided, however the form remained blank. a2. Review of the Facility Verification of Informed Consent, dated May 5, 2011, indicated Resident 13 was to have bilateral side rails up with side rail pads while in bed for safety. However, there was no signature of the physician on the consent form to indicate an informed consent was obtained. There was a consent form, dated June 3, 2011, for the use of Ativan (used for the management of anxiety) 0.5 milligrams (mg) every 8 hours to be given intramuscularly whenever necessary. However, there was no signature of the physician on the consent form to indicate an informed consent was obtained. There was a consent form, undated, for the use of Doxepin (a drug used for the management of depression, anxiety, bipolar disorder) 5 mg into the gastronomy tube	F 514	d. The RN Supervisor assessed resident 21 regarding the use of side rails when in bed and locked for ADL changes, positioning, and mobility. RN Supervisor revised the informed consent and obtained signatures of the attending physician, facility representative and staff, obtaining the consent and dating accordingly. e. The RN Supervisor assessed Resident 28 regarding the use of bilateral padded side rails up and locked while in bed for safety, bilateral hand mittens for combativeness and resistance to care, wheelchair alarm for getting up unassisted, and use of Ambien, Risperdal, and Prozac. RN Supervisor revised the informed consents for use of physical and chemical restraints by obtaining the signatures of attending physician, facility representatives and person obtaining the consent. Consents were dated accordingly. Clarification order regarding use of Ambien, Risperdal and Prozac indicating their use were also obtained from the attending physician, and documented. f. The RN Supervisor assessed resident 24 for appropriate use of side rails up when in bed. Resident 24's current condition does not warrant the need for physical restraint. RN Supervisor revised the consent regarding use of Ativan for anxiety and restlessness, and	

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F 514	Continued From page 50 two times a day. However, there was no signature of the physician on the consent form to indicate an informed consent was obtained. b. On July 26, 2011, at 12:00 p.m., during an interview, Registered Nurse Supervisor 3 (RN 3) stated consents should be completed by the physician. A review of Resident 8's medical record indicated he was admitted to the facility on December 11, 2010, with diagnoses including dysphagia (difficulty swallowing), a tracheostomy (a tube surgically inserted in the throat to assist with breathing) and seizure disorder. Physician's Orders, dated January 22, 2011, indicated Resident 8 was to have bilateral hand mittens to prevent pulling of his tracheostomy and other medical devices. A review of Resident 8's medical records indicated consent for a left hand mitten to prevent pulling of the tracheostomy and other medical devices. The consent was signed by the facility representative on January 24, 2011, and was signed by the physician without a date. Another consent for padded bilateral side rails secondary to the resident's seizure disorder. The consent was signed by the facility representative on December 13, 2010, and was signed by the physician without a date. c. A Review of Resident 9's Admission Records indicated she was readmitted to the facility on June 1, 2011, with diagnoses including left intertrochanteric fracture (left hip fracture), difficulty walking, osteoarthritis (a joint disorder	F 514	obtained attending physician's signature including the signature of facility representative and person obtaining the consent, and properly dated. **Identification of Areas with Potential for Adverse Effect:** Medical records, for all residents with orders for physical and chemical restraints, were reviewed to assure that consents were signed and dated prior to initiation of physical and chemical restraints. Findings revealed none were found affected by the alleged deficient practice. **Systemic Change(s) & Measure(s) of Prevention for Reoccurrence:** The DON in-serviced Licensed Nurses on the facility policy for physical and Chemical Restraint use with emphasis on obtaining consent prior to initiation of physical and chemical restraints once attending physician ordered them. Medical records staff will perform daily audit of the consents to identify completeness of the information such as: the attending physician, responsible party, and staff signature, date signed, medication name, dosage, route, frequency and indicated diagnosis. Findings will be communicated promptly to the RN Supervisor for immediate action. Social service staff will review and document the completeness of the consent form on the Social Service notes on weekly basis. IDT members will review use of	

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F 514	Continued From page 51 manifested by pain and stiffness to the joint), osteoporosis (weakened bones) and muscle weakness. Physician's Orders, dated June 1, 2011, indicated Resident 9 was to receive the following: Effexor 50 milligrams (mg) daily for depression Seroquel 25 mg at bed time for psychosis with dementia Ambien 5 mg at bed time for insomnia Bilateral upper and lower half side rails up and locked when in bed for safety, balance and position secondary to decreased strength and weakness Physician's Orders, dated June 25, 2011, indicated Resident 9 was to have bilateral upper side rails up and locked when in bed for activities of daily living (ADL) changes, mobility and positioning. A review of Resident 9's medical records indicated two consents for bilateral upper half and/or lower half side rails. The side rails were to be up and locked when the resident was in bed for safety, balance and positioning secondary to decreased strength and weakness. The consents were signed and dated by the facility representative on June 1 and June 28, 2011, however, there was no signature or date to indicate who obtained the informed consent. Continued review of the resident's medical records indicated consents for Ambien (no indication for use), Effexor (no indication for use) and Seroquel (no indication for use) all dated by the facility representative on June 1, 2011, however, there was no signature or date to indicate who obtained the informed consent.	F 514	physical and chemical restraint during care plan meeting to check the appropriate use of the restraints and to review consents are signed and dated. RN Supervisor, Social Service Director, and MDS Coordinator will report findings and action taken to the DON on weekly basis. **Monitoring Plan(s):** The DON/her designee will review reports from the RN Supervisor, Social Service Director and MDS Coordinator for implementation, to assure consent will be obtained and dated promptly prior to initiation of restraints. Findings will be reported and discussed at the CQI meeting for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056334	A. BUILDING _____ B. WING _____	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSTAR REHABILITATION & NSG CTR OF SANTA MONICA	1340 15TH STREET SANTA MONICA, CA 90404

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F 514	Continued From page 52 A review of Resident 9's Medication Administration Record (MAR), dated June and July 2011, indicated Resident 9 received Seroquel, Effexor and Ambien as prescribed without a signed informed consent for the use of the medications. d. A review of Resident 21's Admission Records indicated she was admitted to the facility on May 30, 2011, with diagnoses including left hip fracture, history of fall, chronic pain syndrome and osteoporosis. Physician's Orders, dated June 26, 2011, indicated Resident 9 was to have bilateral upper and lower side rails up and locked when in bed for activities of daily living (ADL) changes, positioning and mobility. The informed consent was obtained from the responsible party after an explanation of the risk and benefits and was verified with the physician. A review of Resident 21's medical records indicated two consents. One dated by the facility representative on May 30, 2011, for bilateral upper side rails for mobility. The consent was signed but not dated by the physician. The other consent dated by the facility representative on June 27, 2011, for bilateral upper and lower side rails to be up and locked when the resident was in bed for ADL changes, positioning and mobility was not signed or dated by the physician. Physician's Progress Notes indicated Resident 21's physician was in the facility on July 7, 2011, without signing the consent for bilateral side rails.	F 514		

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

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F 514	Continued From page 53 e. A review of RS 28's Admission Records indicated she was readmitted to the facility on June 21, 2010, with diagnoses including Parkinson's disease (a progressive disorder of the nervous system that affects movement), dementia (a serious loss of mental ability) and psychosis. Physician's Orders indicated the following: March 6, 2011 - Ambien 5 mg at bed time as needed for insomnia. March 6, 2011 - Bilateral full side rails up and locked with side rails padded when in bed. March 7, 2011 - Bilateral hand mittens for combativeness and resistance to care. March 19, 2011 - Prozac 30 mg daily for depression. April 28, 2011 - Ambien 5 mg at bed time as needed for insomnia. April 28, 2011 - Risperdal 0.25 mg two times daily as needed for psychosis. A review of RS 28's medical records indicated two consents for Ambien (no indication for use) and for bilateral side rails up and locked while in bed with pads for safety, dated by the facility representative on March 6, 2011. The physician signed the consent for the Ambien without dating it; he did not sign or date the consent for the bilateral side rails. Continued review of the resident's medical records indicated a consent for bilateral hand mittens for combativeness and resistance to care dated by the facility representative on March 7, 2011, a consent for Risperdal (no indication for use) dated by the facility representative on March 12, 2011, a consent for Prozac (no indication for use) dated	F 514		

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F 514	Continued From page 54 by the facility representative on March 29, 2011, and a consent for a wheelchair alarm related to the resident getting up unassisted, dated by the facility representative on June 13, 2011, all without a physician's signature or date to indicate informed consent has been obtained. A review of the Psychotropic Medication Record and the Nurse's Medication Notes, dated March 2011, indicated RS 28 received Prozac, Risperdal and Ambien without a signed and/or dated consent to administer the medication. Physician's Progress Notes indicated RS 28's physician was in the facility on March 8, 2011, April 30, 2011, May 30, 2011, June 11, 2011, and July 25, 2011, without signing the consents. A facility policy on Informed Consents, revised 2011, indicated the facility will request the physician to obtain informed consent from the resident or the surrogate decision maker. The facility will ensure that the resident, and/or surrogate decision maker gave informed consent prior to the initiation of psychotherapeutic drugs and physical restraints. f. A review of the medical record indicated Resident 24 was admitted to the facility on April 16, 2011, with diagnoses including acute respiratory failure, dysphagia and muscle weakness. A physicians order, dated April 16, 2011, indicated Resident 24 was to have bilateral side rails up and locked when in bed. The orders for the use of the restraints were in place for one month prior to being discontinued on May 17,	F 514		

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F 514	Continued From page 55 2011. A review of the medical record revealed the consent form for the side rails, dated April 16, 2011, had not been signed and dated by the physician. However, the side rails were considered a physical restraint. A second consent, dated April 17, 2011, had the physician's name printed, and not signed, as an indication the informed consent had actually been obtained by the physician. A physicians order, dated May 29, 2011, indicated Resident 24 was to receive Ativan 1 milligram every 12 hours for anxiety and restlessness. A review of the medical record revealed the consent for the use of Ativan was not signed or dated by the physician. According to the Medication Administration Record for June 2011, indicated Resident 24 was to receive Ativan 1 mg daily, twice a day at 9 am and 9 pm. The staff administered the medication to the resident without consent for its use.	F 514		