STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055884	A. BUILDING _____ B. WING _____	08/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN TOMAS CONVALESCENT HOSPITAL	3580 PAYNE AVENUE SAN JOSE, CA 95117

(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 California Department of Public Health during an annual recertification survey conducted from 8/15/11 through 8/22/11. The facility was licensed for 130 beds. The census at the time of the survey was 119 with no bedholds. There were 24 sampled residents and four non-sampled residents. State citations were identified for Health and Safety Code Section 1418.21 and the Federal Code of Regulations, F281. Entity Reported Incident CA00279740 was investigated during the recertification survey and no deficiencies were identified. Representing the California Department of Public Health: 29260, Health Facilities Evaluator Nurse; 25076, Health Facilities Evaluator Nurse; 16614, Registered Dietician, Nutrition Consultant; 29765, Health Facilities Evaluator Nurse; 28150 Health Facilities Evaluator Nurse; and 22899, Health Facilities Evaluator Nurse.	F 000	Preparation and/or execution of this Plan of Correction do not constitute admission or agreement by the provider to the truth of the facts alleged or conclusions set forth on this Statement of Deficiencies. This Plan of Correction is prepared and/ or executed solely because the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq require it. This Plan of Correction constitutes our credible allegation of compliance. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH SEP 19 2011 LICENSING & CERTIFICATION DIVISION SAN JOSE	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157	F157 NOTIFICATION OF CHANGES • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	09/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE Administrator (X6) DATE 9/16/2011

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 157	Continued From page 1 status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the attending physician and responsible party when one of 24 sampled residents (2) had a significant weight loss of 11 pounds (6.1%) in one week and a change in her bilateral leg edema (swelling). Resident 2 had a heart condition that required closed monitoring of their weight and fluid retention manifested as edema. Findings: Resident 2 was admitted to the facility with diagnoses including congestive heart failure (CHF, the heart can no longer pump enough	F 157	The attending Physician and Responsible Party for Resident 2 was notified of significant weight loss of 11 lbs. (6.1%) in one week and the change in Resident 6 bilateral leg edema on 08/16/2011. The attending Physician for Resident 2 reassessed resident on 08/16/2011 and documented a medically acceptable weight loss in his progress notes. The Licensed Nurse reassessed Resident 2 bilateral lower extremities edema on 08/16/2011, updated care plan and obtain order clarification for monitoring extent of edema from attending physician. • How the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: A consulting physician conducted in service on 09/14/2011 to licensed nursing staff regarding accurate assessment of residents with edema. The Director of Nursing conducted in service on 08/26/2011 and on going to licensed nursing staff regarding facility's policy and procedures regarding notification of attending Physician and Responsible	

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F 157	Continued From page 2 blood to the rest of the body) and acute renal failure (sudden loss of the ability of the kidneys to remove waste from the body). The Minimum Data Set (MDS, an assessment tool) dated 6/9/11 indicated Resident 2 had modified independence in cognitive skills for daily decision making. The clinical record for Resident 2 was reviewed on 8/16/11. The physician's order dated 6/19/11 indicated to monitor left and right lower extremity edema (swelling) every shift and notify medical doctor of any changes. The Physician's Progress Note dated 7/31/11 indicated Resident 2 had 2-3 plus pedal bilateral edema (swelling in the feet and ankles) and "can go very quickly from fluid overload to acute renal failure". Continue the same medications, but must keep a close eye on Lasix (medication used to reduce accumulation of excess fluid) dose and monitor. The Treatment Record dated 8/1/11 to 8/16/11 indicated only the nurse's initial for every shift monitoring for the left and right lower extremity edema. There was no indication of the degree of edema. During an observation and interview with Resident 2 on 8/16/11 at 3:15 p.m., she was in her room in bed with a pillow under her feet. She stated her "legs were smaller in size than before." During an interview and record review with licensed nurse D (LN D) on 8/17/11 at 7:30 a.m., she stated when monitoring for edema in the lower extremities the nurse should document the level of edema by using a scale of 1 plus (small	F 157	Party of Weight Variance and assessment on resident with edema. The Licensed Nurse reassessed all residents with edema beginning 08/19/2011 and ongoing, respective residents care plan were reviewed, revised and updated and order clarification obtained from attending Physician in monitoring degree/ depth of edema. The weight variance committee reviewed all residents on weekly weights on 08/16/2011 and Licensed Nurses notified attending Physician and Responsible Party of weight variance of 2.5% and greater. The Director of Nursing conducted in service to Licensed Nursing staff and RNA regarding revised facility protocol on weekly weights on 08/26/2011. • What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility revised weekly weight protocol beginning 09/01/2011. All residents on weekly weight will be done every Sunday by Restorative Nursing Assistant. Licensed Nurse will document result in treatment sheet and notify attending	

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F 157	Continued From page 3 amount of fluid) 2 plus (mild accumulation of fluid) 3 plus (moderate amount of fluid) and 4 plus (severe accumulation of fluid) on the Treatment Record, weekly summary or the nurse's notes. She stated the nurse's notes and weekly summary did not indicate Resident 2's edema was checked every shift and the Treatment Record only had a nurse's initial indicating the edema was monitored every shift. She stated one needs to know the level of edema to indicate if there was a change in the resident's edema and to notify the physician as ordered. She also stated there was no documented evidence in Resident 2's record indicating the physician and responsible party were notified of any changes. The Weight Variance Team Evaluation dated 8/4/11 indicated Resident 2 was recently admitted to the acute care hospital for CHF exacerbation (increase in severity) and had returned to the facility on 7/29/11. The Weekly Weights Record indicated Resident 2's weight was 177 pounds (lbs) on 7/30/11, 179 lbs. on 8/6/11 and 165.9 lbs on 8/13/11. There was a 13.1 lb weight loss in one week from 8/6/11 to 8/13/11. During an interview and record review with licensed nurse E (LN E) on 8/19/11 at 7:15 a.m., she stated Resident 2's edema had gone from a 3 plus to a 2 plus but she had not notified the physician of the change as ordered and there was no indication the physician or responsible party were notified by any nursing shift as ordered. She stated she was aware of the significant weight loss on 8/13/11, but she did not have Resident 2 reweighed and she did not notify the physician or responsible party of the change.	F 157	Physician and Responsible Party of weight variance of 2.5% unless otherwise specified by Physician order within 24 hours. The Registered Dietician will review weekly weights result every Monday and discuss in weight variance meeting for further recommendations and interventions. The Medical Records staff will perform audit every Monday to ensure that attending Physician and Responsible Party are notified of significant weight changes. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Nursing and Nursing Supervisor will monitor compliance, there are two (2) chart audits daily and through clinical observation for resident with edema. For Quality Assurance to audit. The Director of Nursing and Nursing Supervisor will do two (2) random charts review weekly to ensure that attending	

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F 157	Continued From page 4 The facility's undated policy and procedure, "Notification of Attending Physician on Significant Weight Changes," indicated the attending physician and responsible party will be notified of a 5% weight change in a month by the licensed nurse and will document in the resident's health record. The facility's undated policy and procedure, "Edema", indicated the licensed nurse will notify attending physician of any significant changes in edema. The facility's policy and procedure, "Change in Resident's Condition or Status", indicated unless instructed by the resident, the nurse will notify the resident's next-of-kin or representative when there is a change in the resident's physical, mental or physical status; there is a significant weight change.	F 157	Physician and Responsible Party are notified of resident's significant weight loss. For Quality Assurance to audit. Concerns and issues of non compliance will be reported to the Quality Assurance Committee quarterly for tracking, trending and resolution. • Dates when corrective action will be completed: 09/30/2011	09/30/11
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, interview and record review, the facility failed to ensure one of 24 sampled residents (6) and one nonsampled resident (25) were treated with dignity and respect. For Resident 6, there were two postings located on the wall above her bed with care instructions identifying the resident and the care	F 241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Social Service staff interviewed Resident 25 on 09/12/2011 regarding care received and current caregivers. The MDS Coordinator initiated a toileting plan beginning 09/13/2011 for Resident 25.	

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F 241	Continued From page 5 to be given. For Resident 25, the facility failed to treat the resident with dignity when they refused to comply with the resident's request for toileting assistance. Not treating residents respectfully and with dignity could affect a resident's feeling of self-esteem. Findings: 1. Resident 25 was admitted to the facility with diagnoses including Diabetes Type II (elevated blood sugar). Record review was done on 8/15/11 at 11:15 a.m. Resident 25's Minimum Data Set (MDS-a data collection tool) indicated she had the ability to express ideas and wants and was able to understand others. During the initial tour on 8/15/11 at 8:30 a.m. Resident 25 was observed in her wheelchair, and brushing her teeth at her bedside table. During an interview with Resident 25 on the above date and time she stated, "I do have to go to bathroom. She [certified nurse assistant A (CNA A)] told me to brush my teeth first before I can go to the bathroom." She further stated she had to go to the bathroom "real bad." During an interview on 8/15/11 at 8:35 a.m. CNA A stated she told Resident 25 to brush her teeth first before she assisted her to the bathroom. During an interview on 8/19/11 at 11:10 a.m., licensed nurse B (LN B) stated Resident 25 used the toilet with assistance from the certified nurse assistant. She further stated this resident was mostly continent (capable of controlling) of urine and always continent of bowel movements.	F 241	CNA's caring for Resident 25 were in service by Director of Staff Development on 09/13/2011. 2. The Resident's 6 posting were removed for resident's request on 08/16/2011. Care plan reviewed and updated by Licensed Nurse to reflect, reminding resident to asked for assistance before getting out of bed due to fall risk, anticipation of needs and allowing resident to decide to wear her clothes preference at anytime. • How the facility will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Director of Staff Development conducted in service to Certified Nursing Assistants beginning 09/16/2011 and on going resident regarding respect of resident's individuality and dignity. 2. All resident's room with posting were removed and placed in manila folders and marked "Caregiver Instructions" to protect confidentiality and maintained dignity. The folder was placed at each resident's bedside for reference. Care plan were reviewed and updated to all residents with posting to reflect instructions and preferences.	

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F 241	Continued From page 6 During an interview on 8/19/11 at 11:15 a.m. CNA A stated Resident 25 needed "extensive assist and I have to clean her bottom." CNA A further stated, "I have to wheel her into the bathroom. She can't do it by herself." During review of the facility's "Job Description Nursing Assistant" it indicated to assist residents to ensure their cleanliness, grooming, nourishment, rest, activity and elimination in a manner conducive to the resident's comfort and safety. During review on 8/19/11 at 10:30 a.m. of "Addendum to Admission Packet" it indicated, "Please be aware that you as a resident of this facility, has the right to: reside and receive services in the facility with reasonable accommodations of individual needs and preferences..." 2. Resident 6 was admitted to the facility with diagnoses including coronary artery disease. The MDS dated 6/3/11 indicated Resident 6 had modified independence in cognitive skills for daily decision making and needed assistance for transfer and dressing. During the initial tour on 8/15/11 at 8:10 a.m. with licensed nurse I (LN I) two signs with instructions were observed posted on the wall above Resident 6's bed. She stated one of the signs with instructions for Resident 6 to call for assistance before getting out of bed was from a family member. She stated the posted sign indicating to change Resident 6's clothing after church before eating was posted by the social worker. The	F 241	• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Social Service staff will visit and interview resident on daily basis from Monday to Friday and by Nursing Supervisor on Saturday and Sunday to ensure that residents needs are met consistently. For Quality Assurance to audit. The Department Heads will monitor room during morning rounds to ensure that resident's rooms will free from exposed posting. The Interdisciplinary team will discuss with resident and responsible party regarding care received during quarterly care conferences. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Department Heads will interview at least five (5) residents during morning rounds to ensure needs are met consistently and any non compliant issues	

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F 241	Continued From page 7 postings had the room number and name of the resident and were visible to other residents and visitors. During observation and interview with Resident 6 on 8/16/11 at 9:20 a.m., she was sitting in her wheelchair in her room. She stated "I guess I make a mess of my clothes when eating so they put a sign up to let us know that I need my clothes changed after going to church."	F 241	will be brought to the morning stand up meeting for further discussion and resolution. For Quality Assurance to audit. Issues of non compliance will be brought to the attention of the Quality Assurance Committee during quarterly meetings. • Dates when corrective action will be completed: 09/30/2011	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 279	F279 DEVELOP COMPREHENSIVE CARE PLANS • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Resident's 1 care plan was reviewed and updated by Registered Nurse on 08/15/2011 to reflect family concerns/ request such as use of ice water when administering medications, this also include Dental/ oral care plan after each meal and activity of daily living care plan included preference of not getting out of bed earlier than 11AM. 2. The Resident's 2 care plan was reviewed and updated by Registered Nurse on 08/16/2011 to reflect Resident's 2 plan of care with resident's edema and other areas of care.	09/30/11

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F 279	Continued From page 8 review, the facility failed to develop, review and revise ten of 24 sampled residents' (1, 2, 3, 6, 8, 9, 13, 15, 22, and 23) care plans. For Resident 1, the facility failed to develop a comprehensive care plan to address family concerns such as the use of ice water when administering medications, revise the dental care plan to include assisting the resident in brushing his teeth after each meal and the activity of daily living (ADL) care plan to include not getting the resident out of bed earlier than 11 a.m. For Resident 2, the facility failed to review and revise the care plan for edema. For Resident 3, the facility failed to develop a care plan for the use of Coumadin (medication used to prevent blood from clotting). For Resident 6, the facility failed to revise the care plan for fall precautions to include calling for the nurse to assist resident when getting up and the facility failed to revise the ADL care plan to include social worker concerns about changing her clothes after church before eating. For Resident 8, the facility failed to develop a care plan for the use of hydrocodone (medication used to treat moderate to severe pain) to include monitoring for side effects. For Resident 9, the facility failed to develop a care plan for the use of full side rails and failed to develop an activity care plan to address the resident's impaired vision and hearing. For Resident 13, the facility failed to revise the care plan for the use of Seroquel (medication used to treat behaviors) to reflect an increase in the dose and failed to revise the pressure ulcer care plan to include the increase in the size of the pressure ulcer. For Resident 15, the facility failed to develop a care plan for the use of Nortriptyline (medication used to treat depression and chronic pain). For Resident 22, the facility failed to revise the pressure ulcer care	F 279	3. The Resident's 6 care plan was reviewed and updated by Registered Nurse on 09/08/2011 to reflect Resident's 6 preferences of clothes to wear anytime and for staff to provide barrier to protect clothing. Resident's 6 care plans for fall risk was also updated on 09/08/2011 to reflect asking for assistance before getting out of bed. 4. The Resident's 15 care plan was reviewed, revised and updated by Registered Nurse on 09/08/2011 to reflect treatment goals and measurable outcomes with the use of Nortriptyline. 5. The Resident's 8 care plan for pain was reviewed, revised and updated by Registered Nurse on 09/08/2011 to reflect monitoring for adverse reactions/ side effects from medication (Norco) and to monitor resident response to the use of the medication (Norco) in relieving pain. 6. The Resident's 9 care plan was reviewed, revised and updated by Registered Nurse on 09/08/2011 to reflect Resident's 9 preference of using full side rails.	

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F 279	Continued From page 9 plan to include a problem, need or concern and failed to revise the approach when medications were discontinued. For Resident 23, the facility failed to revise the respiratory care plan to include discontinuation of monitoring oxygen saturation levels every shift. Nursing care plans are developed, reviewed and revised to ensure the resident problems are identified and needs are met consistently and safely. Findings: 1. Resident 1 was admitted to the facility with diagnoses including dementia. The Minimum Data Set (MDS, an assessment tool) dated 7/6/11 indicated Resident 1 was moderately impaired in cognitive skills for daily decision making and needed total assistance in activities of daily living (ADLs). During the initial tour on 8/15/11 at 8:10 a.m. with licensed nurse I (LN I) several signs with instructions were observed posted on the walls of Resident 1's room. LN I stated she thought the postings were from the family member, but she was not sure. The clinical record for Resident 1 was reviewed on 8/15/11. An undated note from Resident 1's family member indicated Resident 1 was able to swallow medications better when ice water was used during administration of medications. There was no care plan to address the posted concern from the family member to use ice water when administering medications to Resident 1. The dental care plan dated 8/8/07 and reviewed on 7/11 did not include the family concern to assist Resident 1 to brush his teeth after each meal.	F 279	7. The Resident's 9 activity care plan was reviewed, revised and updated by Activity Director on 09/08/2011 to reflect highly impaired vision and hearing impairment that includes objectives, measurable goals and specific interventions to address hearing and vision problems. 8. The Resident's 13 care plan for Psychotropic was reviewed, revised and updated by Registered Nurse on 08/31/2011 to reflect increase of Seroquel. 9. The Resident's 13 care plan for right buttock wound was reviewed, revised and updated by Registered Nurse on 08/17/2011 to reflect increase in size, treatment and risk factors which includes preference to lay on her back. 10. The Resident's 22 care plan for pressure ulcer was reviewed, revised and updated by Registered Nurse on 08/18/2011 to reflect discontinuation of hydrocortisone and econazole. 11. The Assistant Director of Nursing immediately developed a care plan for Resident's 3 on 08/17/2011 to address potential bleeding tendencies related to the use of Coumadin.	

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F 279	Continued From page 10 The ADL care plan dated 7/6/10 and reviewed on 7/11 did not include the family's instructions to not get Resident 1 out of bed before 11 a.m. During an interview with the director of nurses (DON) on 8/15/11 at 3:50 p.m., she stated Resident 1's family member attended the care conferences and had concerns about the resident's care and trust for the staff caring for the resident. She stated Resident 1's care plans did not include instructions from the family member, but should include those instructions as part of his care. 2. Resident 2 was admitted to the facility with diagnoses including congestive heart failure (CHF, the heart can no longer pump enough blood to the rest of the body) and acute renal failure (sudden loss of the ability of the kidneys to remove waste from the body). The Minimum Data Set (MDS, an assessment tool) dated 6/9/11 indicated Resident 2 had modified independence in cognitive skills for daily decision making. The clinical record for Resident 2 was reviewed on 8/16/11. The physician's order dated 6/19/11 indicated to monitor left and right lower extremity edema (swelling) every shift and notify medical doctor of any changes. The Physician's Progress Note dated 7/31/11 indicated Resident 2 had 2-3 plus pedal bilateral edema (swelling in the feet and ankles) and "can go very quickly from fluid overload to acute renal failure". Continue the same medications, but must keep close eye on Lasix (medication used to reduce accumulation of excess fluid) dose and	F 279	• How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The Director of Nursing, Assistant Director of Nursing, Registered Nurse, Minimum Data Set Coordinators and Nursing Supervisors reviewed forty (40) active clinical records randomly selected to determine compliance with comprehensive care plan beginning 08/23/2011 and ongoing. Deficiencies were addressed and updated as needed. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: To prevent recurrence of this deficient practice, the following practice will take place: 1. The Interdisciplinary Team shall continue to review and complete the care plans of residents within 7 days of admission, quarterly, annually and as needed with significant change in condition.	9/30/2011

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F 279	Continued From page 11 monitor. The Edema care plan dated 7/8/11 was not reviewed and revised when Resident 2 returned from the acute care hospital, to include the physician's order to monitor left and right lower extremity edema, notify the physician with any changes, use Lasix (medication used to reduce fluid retention), and the concern for fluid overload and acute renal failure. During an interview with the assistant director of nurses (ADON) on 8/16/11 at 2:15 p.m., she stated when a resident leaves the facility for the acute care hospital and returns to the facility, the care plans should be reviewed and revised to reflect the resident's status. 3. Resident 6 was admitted to the facility with diagnoses including coronary artery disease. The MDS dated 6/3/11 indicated Resident 6 had modified independence in cognitive skills for daily decision making and needed assistance for transfer and dressing. During the initial tour on 8/15/11 at 8:10 a.m. with licensed nurse I (LN I) two signs with instructions were observed posted on the wall above Resident 6's bed. She stated one of the signs with instructions for Resident 6 to call for assistance before getting out of bed was from a family member. She stated the posted sign indicating to change Resident 6's clothing after church before eating was posted by the social worker. The clinical record for Resident 6 was reviewed on 8/16/11. The fall precaution care plan dated 6/16/10 and reviewed on 6/3/11 did not include as	F 279	2. The Licensed Nurses are responsible for updating the care plans as changes of condition occur on daily basis and during the scheduled weekly nursing progress notes. 3. Other member of Interdisciplinary Team shall update their care plans as the need arises. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Nursing or designee will review at least two (2) clinical records a day to determine compliance with comprehensive care plans. Deficiencies shall be corrected immediately. For Quality Assurance to audit. The Medical Records staff shall audit physician's orders, telephone orders on daily basis from Monday to Friday and by Nursing Supervisor on weekend to ensure that orders or changes in condition are addressed in the care plan. A report shall	

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F 279	Continued From page 12 an approach, instructions for Resident 6 to call for assistance before getting out of bed. The ADL care plan dated 6/16/10 and reviewed 6/3/11 did not include as an approach, the social worker's instructions to change Resident 6's clothes after attending church and before eating. 4. Resident 15 was admitted to the facility with diagnoses including peripheral (arms and legs) neuropathy (damage to nerves of the peripheral nervous system) and depression. The MDS dated 5/6/11 indicated Resident 15 was independent in cognitive skills for daily decision making and had episodes of pain in her hands and legs. The clinical record for Resident 15 was reviewed on 8/18/11. The neurology physician's order dated 8/16/11 indicated Nortriptyline 10 milligram (mg) tablet by mouth (po) every (q) night for one week, then two tablets po q night for one week, then three tablets po q night. During an interview and record review with licensed nurse D on 8/18/11 at 3:10 p.m., she stated the order for the Nortriptyline was written by the neurologist and the medication was prescribed for the resident's pain. She stated the Nortriptyline was written on the pain management care plan as an approach, but should have had a care plan developed with the use of Nortriptyline with treatment goals and measurable outcomes. The facility's undated policy and procedure, "Care Plans - Comprehensive", indicated "Care plans are revised as changes in the resident's condition dictates." Care plans for each resident should "Incorporate identified problem areas; Incorporate risk factors associated with identified problems;	F 279	be submitted to the Director of Nursing weekly for corrective action. Issues of non compliance will be brought to the attention of Quality Assurance Committee during quarterly meeting for tracking, trending and resolutions. • Dates when corrective action will be completed: 09/30/2011	9/30/11 and on going

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F 279	Continued From page 13 and "reflect treatment goals and objectives in measurable outcomes." 5. Resident 8 was admitted to the facility with diagnoses including multiple sclerosis (progressive disease that damaged the nerves). During initial tour observation on 8/15/11 at 8:30 a.m., Resident 8 was resting in bed, awake and alert and responded slowly to questions. A review of the physician orders from 12/24/10 through 6/11 indicated Resident 8 had received Norco (a drug used to releive moderate to severe pains) for pain. A 12/25/10 and 6/29/11 care plan "Alteration in comfort" did not include goals to monitor the resident's response to the medication and to watch for adverse reactions from the medications (unpleasant symtoms or event due to/or associated with a medication). During interview on 8/22/11, licensed nurse C (LN C) stated she would monitor the resident by checking the pain level after administering medication. Also, LN C was not able to state the side effects to be monitored when a resident received Norco. She stated the interventions in the care plan for Norco should include the side effects to monitor. The facility's undated policy and procedure "Care plans- comprehensive" indicated it was the policy of the facility to develop a comprehensive care plan for each resident that reflected treatment goals and objectives with measurable outcomes.	F 279		

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F 279	Continued From page 14 6. Resident 9 was admitted to the facility with diagnoses including multiple falls and malaise (weakness). The Minimum Data Set (MDS, an assessment tool) dated 7/18/11 indicated Resident 9 had a history of falls. During observation on 8/16/11 at 7:30 a.m., the resident was awake and alert with full side rails up on both sides of the bed. An 8/16/11 record review indicated the physician ordered full siderails while in bed for safety per resident's request. During interview on the same date at 10:a.m., the director of nurses (DON) stated the full side rails should be care planned to reflect the care provided to the resident. There was no evidence indicating the full siderails were care planned. 7. A record review of the activity care plan on 8/17/11 indicated Resident 9 had "Highly" impaired vision and hearing impairment. The care plan did not include the objectives and goals. The care plan also did not identify specific interventions to address the vision and hearing problems. During interview on the same date, activities director (AD) reviewed the record and stated the care plan should include Resident 9 should wear glasses, sit in the front and wear hearing aids during activity program. An undated facility's policy and procedure, "Activity program" indicated the goal was to	F 279		

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F 279	Continued From page 15 provide opportunity for fun, enjoyment and social stimulation. 8. Resident 13 was admitted to the facility with diagnoses of dementia (deteriorative mental state), depression (sadness), and chronic pain. A physician's order dated 4/8/11 indicated Resident 13 was to receive Seroquel (psychotropic medication used to manage behaviors) 50 milligrams (mg) every evening at 9 p.m. for behavioral problems exhibited by yelling, screaming and other behaviors. A physician's order dated 7/20/11 indicated Resident 13's Seroquel was to be increased to 75 mg every evening. Resident 13's care plan for "Psychotropics" dated 4/9/09 was not revised to reflect the physician's order to increase Seroquel from 50 mg to 75 mg on July 20, 2011. During an interview on 8/17/11 at 8:45 a.m. the director of nurses (DON) stated, "When there is a change there should have been a care plan update." The facility's undated policy and procedure, "Care Plans - Comprehensive" indicated "Care plans are revised as changes in the resident's condition dictates." 9. A physician's order dated 8/5/11 indicated Resident 13's right buttock abrasion should be cleansed with normal saline, wound gel applied, and covered with a dry dressing every shift.	F 279		

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F 279	Continued From page 16 During an observation of a dressing change on 8/15/11 at 2:30 p.m. to Resident 13's right buttock, licensed nurse C (LN C) stated the wound had increased in size from 0.5 cm (centimeter) by 1.0 cm. on 8/5/11 to 1 cm by 2 cm today. During an interview on 8/17/11 at 8:45 a.m. the DON stated there should have been a care plan update regarding the increase in size of Resident 13's pressure ulcer. During an interview on 8/17/11 at 7:50 a.m. LN B stated Resident 13 preferred to lay on her back. She further stated it was an "FYI" (for your information) and was not listed on any care plan. Record review on 8/17/11 at 8:25 a.m. of "Risk for Pressure Ulcers Care Plan" dated 3/2/11, was not revised or updated to reflect Resident 13's change in size and treatment of her presure ulcer. The care plan did not address Patient 13's problem she preferred to "lay on her back." The facility's undated policy and procedure, "Care Plans - Comprehensive" indicated care plans for each resident should "Incorporate identified problem areas; Incorporate risk factors associated with identified problems; and "reflect treatment goals and objectives in measurable outcomes; . . " 10. Resident 22 was admitted to the facility with diagnoses that included cellulitis (a skin infection). A physician's order dated 8/12/11 indicated Resident 22's hydrocortisone cream (a skin rash	F 279		

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F 279	Continued From page 17 medication) and econazole (an anti-fungal medication) cream were discontinued. A care plan dated 8/12/11 "Risk for Pressure Ulcers Care Plan" for Resident 22 listed hydrocortisone and econazole as ordered for an approach to treatment. The "Problem, Need, Concern" had no areas checked that applied to Resident 22. During an interview on 8/18/11 at 11:40 a.m. licensed nurse G (LN G) stated, "Care plans should be updated as medications are discontinued or added." LN G further stated the hydrocortisone and econazole were supposed to be discontinued from Resident 22's care plan and were not. During review of an undated policy and procedure "Care Plans - Comprehensive" it indicated care plans for each resident should "Incorporate identified problem areas; Incorporate risk factors associated with identified problems; and "reflect treatment goals and objectives in measurable outcomes; . . " 11. Resident 3 was admitted to the facility with the diagnoses including atrial fibrillation (irregular heart beat). The MDS dated 8/12/11 indicated Resident 3 was cognitively intact and able to decide for herself. A record review on 8/7/11 of a physician order dated 8/10/11 indicated Resident 3 was receiving Coumadin (medication to prevent blood clotting) 2 milligram by mouth at hour of sleep. There was no care plan developed to address the potential bleeding tendencies related to the use of	F 279		

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F 279	Continued From page 18 Coumadin. During an interview on 8/17/11 at 10:20 a.m., the assistant director of nursing (ADON) stated there was no anticoagulant (a substance to prevent coagulation) care plan in the chart, only the blood test to monitor the effect of the Coumadin. The facility's undated policy and procedure, "Using the Care Plan" indicated completed care plans will be placed in the resident's chart and daily care and documentation must be consistent with the resident's care plan.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, The facility failed to ensure the physician's order for Norco 5/325 (a narcotic pain medication mixed with Tylenol 325 milligrams (mg) was followed for one of 24 sampled residents (8). Resident 8 received a double dose of narcotic when staff administered Norco 10/325 instead of the Norco 5/325 as ordered. Also, Resident 8's order for Morphine Sulfate (a narcotic pain medication) was not administered every 12 hours as ordered by the physician in June 2011. The facility also failed to follow the physician orders for one non-sampled resident (26) when	F 281	F281 D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident 8 order of Norco was discontinued on 07/23/2011 from the acute hospital however restarted on 08/15/2011 per doctor's order as "Norco 5/325 mg 1 tablet by mouth every 4 hours as needed for moderate pain and Norco 10/325 mg 1 tablet by mouth every 4 hours as needed for severe pain." The Licensed Nurse confirmed stock of Norco with RN Supervisor on 08/15/2011 to ensure correct dosage is available for administration when needed.	09/30/11

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F 281	Continued From page 19 Resident 26 was given eight doses of two Percocet 5/325 (a narcotic medication mixed with 325 mgs of Tylenol) instead of Percocet 10/325 as ordered by the physician. Findings: 1. Resident 8 was admitted to the facility with diagnoses including multiple sclerosis (progressive disease that damages the nerves) and respiratory failure (condition in which not enough oxygen passes from the lungs into the blood). The Minimum Data Set (MDS, an assessment tool) dated 7/27/11 indicated Resident 8 was moderately impaired in cognitive skills for daily decision making. During an observation on 8/15/11 at 8:30 a.m., Resident 8 was resting in bed, awake and alert. She responded slowly to questions and her speech was not clear. The clinical record for Resident 8 was reviewed on 8/15/11. On 12/24/10 at 5 p.m., a physician ordered to give Norco 5/325 mg one tablet PO every four hours for moderate pain and two tablets (tabs) for severe pain. An "Individual Patient's Narcotic Record" indicated on 1/28/11, 3/2/11, 3/5/11, 3/6/11, 3/12/11, 3/13/11, 3/18/11, 3/24/11, 3/26/11, 3/30/11, 4/22/11, 5/1/11, 5/11/11, 5/12/11, 5/21/11, 5/24/11, 6/15/11, and 6/19/11 (18 doses) that staff removed Norco 10/325 mg from the locked box and inaccurately documented on the MAR they gave Norco 5/325 mg. Staff continued to administer the wrong dosage of medication to Resident 8. Also, on 5/12/11 staff administered two Norco 10/325 mg tablets at one time to Resident 8.	F 281	2. Resident 8 is no longer on Morphine Sulfate effective 06/29/2011. There was a transcription error in the Medication Administration Record but showed in the Controlled Drug record that it was pulled out in the month of June 2011 until 06/28/2011. 3. Resident 26 Percocet order was changed to 10/325 mg on 08/10/2011 and correct dosage arrived on 08/16/2011. The Licensed Nurse confirmed the correct stock of Percocet with Registered Nurse Supervisor. The Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Director of Staff Development conducted and audit on August 17,19 and 21, 2011 on all residents who are on narcotic to ensure that stock medication on hand matches the physician's order and each narcotic medication are accountable for signing both medication administration record and controlled drug record. The Pharmacy Nurse consultant will conduct a three way audit on all resident's medications by 09/07/2011, 09/08/2011 and 09/09/2011.	8/21/2011

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F 281	Continued From page 20 During interview on 8/16/11 at 3:50 a.m., the assistant director of nurses (ADON) reviewed the records and stated she could not explain what happened. She acknowledged the licensed nurses gave the wrong dosage of Norco to Resident 8. She stated, "This should not happen." During interview on 8/17/11 at 11:40 a.m., the registered pharmacist B (RPH B) stated he was concerned staff was not administering Norco as prescribed by the physician. 2. Resident 8's record review was conducted on 8/19/11. On 1/5/11 the physician ordered Morphine Sulfate 30 mgs SR (sustained release) every 12 hours. A 6/11 Medication Administration Record (MAR) also indicated to give Morphine Sulfate SR (sustained release) 30 milligrams (mgs) one tablet by mouth every 12 hours. However, staff only documented they administered the morphine once a day to Resident 8 at 9 a.m. daily instead of every 12 hours (two times daily) as prescribed by the physician. During interview on 8/22/11 at 11:00 a.m., the director of nurses (DON) reviewed the record and stated she could not explain what happened. The undated facility policy, "Administration of Drugs" indicated medications should be administered in accordance with the written orders of the physician. A job description "Charge nurse" indicated licensed nurses are responsible for administering and charting medications according to the	F 281	The Director of Nursing, conducted in service to licensed nursing staff beginning 08/21/2011 and ongoing regarding compliance in implementing the facility's policy and procedure on "Administration of Drugs". Topic include the role of the licensed nurse in administering medication to ensure that the right resident, medication, dosage, time, route, indication and additional information for as needed medication must include complaints/symptoms and result must be noted and signed by the administering nurse. • Description of the monitoring process to prevent the recurrence of the deficiency: The Director of Nursing in service Medical Records staff regarding the importance of consistent auditing of Medication Administration Record on August 23, 2011.	

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F 281	Continued From page 21 physician's order. 3. Resident 26 was admitted to the facility with diagnoses including chronic pain syndrome. The 6/27/11 MDS indicated Resident 26 understood others, was understood, had constant pain which made it hard to sleep at night and limited day-to-day activities. According to the MDS the worst pain the resident had over the last five day period prior to completion of the MDS was eight on a scale of zero to ten (zero indicating no pain and ten the worst possible pain rating). Record review was conducted on 8/15/11 at 4:10 p.m. The 8/10/11 physician's order at 4:53 p.m. indicated Resident 26's Percocet (a narcotic pain medication containing oxycodone) order was changed from 5/325 mg (a unit of measure) to 10/325 mg every three hours as needed. The entry on the back of the 8/11 MAR found on the medication cart indicated nursing gave Resident 26 two 5/325 mg Percocet instead of one 10/325 mg as ordered by the physician on 8/10/11 at 4:53 p.m. giving two times the dose of Tylenol. The entries on the back of the 8/11 MAR, indicated the 5/325 mg Percocet dosing continued on 8/10/11 at 9:30 p.m., 8/11/11 at 1:30 a.m., 8:00 a.m., 12:00 p.m.; and 4:00 p.m., and 8/12/11 at 5:30 p.m., and 9:00 p.m. During an interview and record review on 8/16/11 at 8:35 a.m., the director of nurses (DON) stated licensed nurses gave Resident 26 the wrong Percocet dosage when they administered two Percocet 5/325 mg instead of one Percocet 10/325 mg tablet after the physician changed the Percocet order. DON stated the most likely	F 281	The Medical Records staff will do daily audit (Monday-Friday) on residents that are on controlled medication to match log sheet and medication administration record. Medical Records audit report will be given to the Director of Nursing on a weekly basis and disciplinary action will take place to Licensed Nurse that are non compliant. The Licensed Nurse will confirm medication received from the pharmacy by checking Medication Administration Record each time delivery arrived. Controlled Medication will be confirmed by two (2) Licensed Nurses. During Endorsement of Controlled Medication by the incoming Licensed Nurse and outgoing Licensed Nurse: the incoming Licensed Nurse will confirm in the Medication Administration Record each narcotic medication that were logged out by the outgoing shift. The Director of Nursing or designee will do a daily two (2) random medication audit to ensure medications are given as ordered and correct stock of medications are on hand by observation during medication pass. For Quality Assurance to audit.	

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F 281	Continued From page 22 reason the 5/325 mg Percocet was given instead of the 10/325 mg was because often times there were delays in the delivery of new narcotic orders because of time consuming documentation which had to be completed prior to the delivery of the drug. According to the facility's 12/3/03 "Charge Nurse Job Description" duties of charge nurses include "preparing, administering and charting medications according to the physician's order and as directed by the Procedures Manual." According to the facility's "Administration of Drugs" policy and procedure, the nurse administering the medications "must record the date, time, dosage, route, complaints/symptoms, results achieved from administering the drug, the time results were noted and the signature and title of the person administering the drug....Prior to administering the resident's medication the nurse should compare the drug and dosage schedule on the resident's MAR with the drug label...if there is any reason to question the dosage or the schedule, the nurse should check the physician's orders."	F 281	The Pharmacy Nurse Consultant will continue to do monthly medication review to ensure that medications are administered as physician's order. The Pharmacy Nurse Consultant will do a quarterly three (3) way audit on stock medications and physicians orders; findings will be given to the Administrator and Director of Nursing. For Quality Assurance to audit. Any issues of non compliance will be brought to the attention of the Quality Assurance Committee on a monthly basis for tracking, trending and resolution. D. Date when corrective action will be completed: 09/30/2011	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 282	F282 SERVICES QUALIFIED PERSONS • How corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice: There was no Physician's order for oxygen saturation check since admission for Resident's 23 and had not required the use of oxygen since admission.	09/30/11

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F 282	Continued From page 23 failed to implement the care plan to monitor the oxygen saturation level of one of 24 sampled residents (23). Findings: Resident 23 was admitted to the facility with diagnoses of sepsis (infection), ventilator (a mechanical device for artificial breathing) associated with pneumonia (inflammation of the lungs), and asthma (difficulty breathing). A care plan dated 06/09/11 "Respiratory Care Plan" reviewed on 8/17/11 at 2:45 p.m. indicated Resident 23's "Approach/Actions Taken" included "Check oxygen saturation Q (every) shift and PRN" (as needed). During an interview on 8/17/11 at 2:55 p.m., the director of nurses (DON) stated the oxygen check every shift and as needed for Resident 24 "has not been done and is not documented" according to the care plan.	F 282	The MDS Coordinator reassessed Resident 23 on 08/17/2011 respiratory status and noted stability of condition that will not require oxygen saturation check every shift. Resident's 23 care plan was reviewed, revised and updated by Registered Nurse on 08/17/2011. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: (continued on continuation sheet)	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the necessary care and services to attain the highest practicable	F 309	F309- E PROVIDE CARE/ SERVICES • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Director of Staff Development constructed 1:1 in service to CNA O and CNA F on 08/16/2011regarding accurate documentation of meal intake for Resident 3.	09/30/11

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F 282	Continued from page 24.	F 282	The Director of Nursing conducted in service to licensed nursing staff on 09/08/2011 regarding implementation of plan of care consistently. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Interdisciplinary Team shall review and complete care plans of residents within 7 days of admission, quarterly and annually with significant change in condition. The Registered Nurse Supervisor shall review residents care plan intervention within 7 days of admission to ensure it still applies to resident. The Licensed Nurse are responsible for update care the care plans as the need arises. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: (continued on next page)	09/30/11

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F 282	continued from continuation sheet	F 282	(continued from continuation sheet) The Director of Nursing or designee will review at least 2 charts a day by reviewing residents care plan interventions. Issues on non compliance will be brought to the attention of Quality Assurance Committee during the quarterly meeting for review or recommendations. • Dates when corrective action will be completed: 09/30/2011	09/30/11

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F 309	Continued From page 24 physical, mental, and psychosocial well-being for eight of 24 sampled residents (2, 3, 4, 8, 13, 16, 17, and 22). For Resident 2, the facility failed to monitor edema and a significant weight loss according to the facility's policy and procedure. For Resident 3, the facility failed to accurately calculate food consumption percentage for a therapeutic diet. For Resident 4, the facility failed to clarify a nasogastric tube (a plastic tube inserted through the nose into the stomach for nutrition) size with the physician before insertion. Resident 8 was not reassessed to verify she received pain relief after the licensed nurses administered Norco 10/325 (a narcotic pain medication mixed with Tylenol 325 milligrams (mg). Also, Resident 8 had no order for Morphine sulfate (a narcotic pain medication) after she returned from the acute care hospital in July, despite having been on Morphine Sulfate around the clock prior to her stay in the acute care hospital. For Resident 13, the facility failed to follow a physician's order to increase the dose of Seroquel (medication used to manage behaviors). For Residents 16 and 17, the facility failed to follow the facility's policy and procedure for the care and assessment of a dialysis patient. For Resident 22, the facility failed to ensure the resident was reassessed for pain after administering a pain medication. Findings: 1. Resident 3 was admitted to the facility with diagnoses including atrial fibrillation (abnormal heart beat). The Minimum Data Set (MDS, an assessment tool for residents) dated 8/12/11 indicated Resident 3 was cognitively intact and independent in the activities of daily living. A record review of the monthly vitals and weight	F 309	2. The Licensed Nurse assessed Resident's 17 AV shunt site immediately and intervened to monitor for further bleeding on 08/18/2011, the Licensed Nurse initiate plan of care for further intervention and notify attending Physician and Responsible Party. No further episode of bleeding noted on the AV shunt site since 08/18/2011 to present. 3. The Licensed Nurse contacted the dialysis center for Resident 17 to ensure that Epogen was administered in the dialysis center every Monday, Wednesday and Friday. Contact date: 09/07/2011 4. The Licensed Nurse obtained classification of order from attending Physician for Resident's 4 Nasogastric tube size on 08/16/2011. 5. The Resident 22 is no longer in the facility. The Director of Nursing conducted 1:1 in service to licensed nursing regarding pain assessment before and after administering pain medications. 6. The attending Physician and Responsible Party for Resident 13 were contacted by licensed nurse regarding increase Seroquel order was not brought on to August Medication Administration Record on 08/15/2011.	

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F 309	Continued From page 25 record on 8/15/11 indicated Resident 3 lost 5% in one month (135 pounds (lbs) to 128 lbs). During lunch observation and interview with Resident 3 on 8/15/11 at 12:45 p.m., Resident 3 did not touch her vegetable, turkey and corn on her plate. She only consumed a bowl of soap and 6 ounces of fortified (added calories and protein) juice. Resident 3 stated she did not like the food. During record review on 8/15/11, the Activity of Daily Living record for food consumption percentages indicated Resident 3's consumption percentage was 70% for lunch that day. During an interview with the director of staff development (DSD) on 8/17/11 at 2:25 p.m., DSD stated staff followed the instruction on the Meal Consumption Documentation Guide. The facility's Meal Consumption Documentation Guide indicated to subtract the amount of food items on the tray from 100% to obtain the percentage of consumption. Appetite Considered as: 0-5% = very poor, 10-30% = poor, 35-65% = fair, 70-85% = good, 90-100% = excellent. "If a resident receives a high protein drink or supplement drink with meals it is not figured in percentage of food eaten. Documentation should reflect the percentage of consumption plus a notation regarding a high protein drink consumed or refused". During an interview with certified nurse assistant O (CNA O) on 8/17/11 at 2:35 p.m., she stated Resident 3 finished all her food, she documented 100% for lunch.	F 309	Order to resume Seroquel 75mg reinstated on 08/15/2011. 7. Comprehensive pain assessed was completed by Licensed Nurse on Resident 8 on 09/02/2011. The Director of Nursing conducted in service to licensed nursing staff on 08/21/2011and on going regarding importance of pain assessment before and after administering pain medication. 8. Resident 8 readmitted from acute hospital on 06/29/2011 in stable condition post respiratory failure. Morphine order no longer exist in the inter facility transfer sheet on 06/29/2011. The Registered Nurse conducted a comprehensive pain assessment on 09/02/2011 for resident 8 to ensure pain is managed with current regimen. The attending Physician was contacted on 09/09/2011 regarding prior Morphine order, Physician declined to reinstate Morphine due to chronic respiratory failure, pain is managed by current regimen. 9. The Resident 2 edema to bilateral lower extremities were reassessed by Licensed	

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F 309	Continued From page 26 During an interview on 8/18/11 at 9 a.m. with certified nurse assistant F (CNA F), she stated Resident 3 had consumed 2 bowls of soup on 8/15/11 for lunch and did not document the second bowl of soup given to Resident 3 because she was not aware to document food that was eaten. During an interview with DSD on 8/18/11 at 9:10 a.m., she stated facility should change the Meal Consumption Percentage Guide to a point system which was easy and simple to follow to avoid inaccurate calculations of residents' food consumption. 2. Resident 17 was admitted to the facility with diagnoses including end stage renal disease. The Minimum Data Set (MDS, an assessment tool for residents) dated 6/11/11 indicated Resident 17 was cognitively intact and able to decide for himself. A record review on 8/17/11 of a physician's order dated 7/24/09 indicated Resident 17 received renal dialysis (a medical procedure for removal of waste products in the blood like a normal kidney would eliminate) three times a week (MWF, Monday, Wednesday, Friday). During an observation of Resident 17 on 8/18/11 at 9:20 a.m. in his room, a stain of fresh blood in the linen at the side of the bed was noted. When Resident 17 uncovered his left arm more fresh blood stain was noted underneath his arm. On examination of his arm, the arterial/venous shunt (A-V shunt, a device implanted in the body to redirect a body fluid from one vessel to another)	F 309	Nurse using facility's guidelines in assessing edema on 08/16/2011 by documenting the degree/ scale of edema. The degree/ scale of edema shall be documented in resident's Treatment Administration Record. 10. The dialysis center for Resident 2 was contacted by Licensed Nurse on 9/08/2011 to obtained documentation proof of Epogen administration as ordered. The Licensed Nurse also informed the dialysis center of prompt completion of facility's dialysis communication form for continuity of care. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Director of Staff Development and Registered Dietitian continue to observed meal times and randomly asked Certified Nursing Assistant of diet percentage taken by resident to assess accuracy of staff documentation. For Quality Assurance to audit. 2. Residents on dialysis were reviewed on 08/23/2011.	

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F 309	Continued From page 27 on his left arm was slightly moist with blood. Licensed nurse L (LN L) was notified and the site was cleaned and observed for bleeding. During an interview with LN L on 8/18/11 at 9: 30 a.m., LN L stated he did not assess Resident 17 during his medication pass at 7:30 a.m. The facility's policy and procedure dated 7/08, "Dialysis, Coordination of Care and Assessment of Resident," indicated to "monitor access site for any skin problems, s/s of infection, pain, edema, bleeding, drainage and call MD if any occur." 3. Also, during a record review of the physician's order on 8/18/11 at 9:30 a.m., Resident 17 was to receive Epogen (a medication used to increase the number of red blood cells) 3,300 units subcutaneous given at a dialysis center every MWF for anemia. Review of the nursing facility/dialysis unit record dated 7/18/11, 7/8/11, 7/25/11, and 8/17/11 indicated no medication was given during dialysis on those dates. During an interview with LN L on 8/18/11 at 10:00 a.m., LN L stated Resident 17 should have received the medication during dialysis on those dates. Staff should have called the center to clarify. LN L further stated Resident 17 did not return from dialysis during his time and he did not clarify it. The facility's dialysis intervention protocol indicated a dialysis communication form will be completed by the facility prior to dialysis. The licensed nurse will complete the pertinent information needed and the form will be sent with the resident as a form of communication to the	F 309	No other resident found to have deficient practice on all of AV shunt care. A consulting Physician conducted in service on 09/14/2011 to licensed nursing staff regarding care for resident on dialysis. 3. The Licensed Nurse reviewed resident on dialysis beginning 08/23/2011 and ongoing to ensure that dialysis communication form is completed. The Licensed Nurse must contact the dialysis center in the event that dialysis communication form is incomplete. 4. No other resident is affected by the deficient practice of not having a Nasogastric tube size. 5. The Director of Nursing conducted in service on 08/21/2011 regarding pain assessment which include but not limited to facility's policy and procedure for pain and pain assessment before and after administering pain medications. 6. The Licensed Nurse audit Physician's order to all residents to ensure that all pain order are transcribed in the Medication Administration Record beginning 08/23/2011 and ongoing.	

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F 309	Continued From page 28 dialysis center. The dialysis center will complete the form which includes medication administered during dialysis and sent back with the resident upon return to SNF. Licensed nurse will review the dialysis communication form and complete information needed. The facility's policy and procedure, "Dialysis Coordination of Care and Assessment of Resident" dated 7/08, indicated the dialysis center, by telephone or in writing, will notify the facility of the following: The resident's vital signs and weight after dialysis. Any medication given during dialysis care". 3. Resident 4 was admitted to the facility with diagnoses including stroke (a decreased supply of blood to the brain). The Minimum Data Set (MDS, an assessment tool for residents) dated 4/18/11 indicated Resident 4 was severely cognitively impaired and totally dependent on staff assistance during activities of daily living. Record review on 8/16/11 of a physician's order dated 10/8/09 indicated Resident 4 had a nasogastric tube (NGT, a plastic tube inserted into the nose for nutrition) inserted for tube feeding. During an observation of Resident 4 in her room on 8/15/11 at 10:40 a.m., Resident 4 was facing the window with her eyes closed in an inclined position and the NGT was clamped. The NGT was big for her size and the tubing was visually long. During an interview with licensed nurse C (LN C) on 8/16/11 at 10:45 a.m., she could not identify	F 309	The Director of Nursing conducted in service to nursing staff on 08/21/2011 regarding transcription of orders to Medication Administration Record. 7. The Licensed Nurse reassessed all residents with edema beginning 08/19/2011 and on going to ensure that edema is assessed per facility's policy and procedure. 8. The Director of Nursing conducted in service on 08/29/2011 regarding the importance of reviewing the dialysis communication form each time the residents comes back from dialysis to maintained continuity of care. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The facility revised protocol in meal percentage calculation to a point system beginning 09/01/2011 for better monitoring and accuracy for resident's meal intake. The Registered Dietitian and Director of Staff Development conducted in service beginning 08/23/2011 and ongoing regarding revised protocol in calculation of meal intake.	9/30/2011

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F 309	Continued From page 29 the NGT tube size. There was no written NGT tube size in the physician's order. During an interview with the assistant director of nursing (ADON) on 8/16/11 9 a.m., ADON stated the NGT tube size was what was available in our stock. During an interview with the director of nursing (DON) on 8/17/11 at 9:05 a.m., DON stated there was no documented NGT tube size, staff should have clarified with the physician. Facility's undated policy and procedure, "Nasogastric Tube Insertion" indicated nasogastric tubes require a physician's order specifying the rate, tube size, amount, and type of solution. 4. Resident 22 was admitted with diagnoses that included cellulitis (a skin infection). A physician's order dated 8/11/11 indicated Resident 22 was to receive one Percocet 10/325 milligrams (mg) (a narcotic/analgesic pain medication) every four hours as needed for moderate pain. A physician's order dated 8/11/11 indicated "monitor pain scale qs (every shift) using scale 0-10 and offer medication as ordered": 0 = no pain; 1-3 = mild pain; 4-6 = moderate pain; 7-10 = severe pain." During review of Resident 22's "Nurses Medication Notes" on 8/18/11 at 9:35 a.m. it indicated Percocet was administered to Resident 22 on 8/12/11 at 9 p.m., 8/13/11 at 4 p.m. and 9	F 309	2. The Licensed Nurses shall review the dialysis communication form before and after dialysis, the Licensed Nurse must contact dialysis center if information is needed. The Nursing Supervisor will review resident's record that are on dialysis every other day to ensure dialysis communication form is completed timely. 3. The Medical Record staff will conduct a daily audit on Medication Administration Record to ensure compliance in pain assessment before and after pain medication. For Quality Assurance to audit. Medical Records will provide the Director of Nursing a copy of the pain assessment audit. 4. The Medical Record staff will conduct audit on new admission on Nasogastric tube to ensure tube size is included in the Physicians order. 5. The night shift Licensed Nurse will do a daily 24 hour audit on residents health record for new order to ensure that orders are transcribed in Medication Administration Record. For Quality Assurance to audit	

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F 309	Continued From page 30 p.m., 8/14/11 at 11 a.m., and 8/17/11 at 8:30 a.m. The initial pain scale was documented as 5-6/10 which indicated moderate pain on the pain scale. There was no documentation of the pain scale results achieved after the administration of the pain medication. During an interview on 8/18/11 at 9:30 a.m. licensed nurse G (LN G) stated, when medicated for pain the nurses are supposed to go back and ask the resident if the pain was relieved one to two hours after the pain medication is given. Also, ask what is the pain level using the pain scale from one to ten with ten being the worst pain. During review on 8/19/11 at 10:30 a.m., the facility's undated policy and procedure, "Resident Rights: Pain Management" indicated when monitoring the effectiveness of interventions to alleviate pain and promote patient comfort, acceptable level of pain shall be considered as resident care outcome or goal. During review on 8/19/11 at 10:35 a.m., the facility's policy and procedure, "Administration of Drugs" indicated when PRN (as needed) medications are administered, the nurse must record any results achieved from administering the drug and the signature and title of the person administering the drug. 5. Resident 13 was admitted to the facility with diagnoses including dementia (deteriorative mental state). A physician's order dated 4/8/11 indicated Resident 13 was to receive Seroquel (medication used to manage behaviors) 50 milligrams (mg)	F 309	6. The Nursing Supervisor shall audit the resident Health Record and Treatment Administration Record of resident with edema daily to ensure that accuracy of assessment is in place. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Nursing or designee will review at least one (1) resident with edema daily, this shall be done through chart review and clinical assessment. For Quality Assurance to audit. The Director of Nursing or designee will review at least one (1) resident health record every other day to ensure that dialysis communication forms are completed. For Quality Assurance to audit.	

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	055884	A. BUILDING _____ B. WING _____	08/22/2011

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F 309	Continued From page 31 every evening at 9 p.m. for behavioral problems exhibited by yelling, screaming, and other behaviors. Review of a "Physician's Progress Note" dated 7/20/11 indicated Resident 13 "failed GDR (Gradual Dose Reduction), behavior escalates" and "difficult to redirect." Increase Seroquel to 75 mg qhs (every evening). A physician's order Dated 7/20/11 indicated Resident 13's Seroquel was increased to 75 mg every evening. During review of "Resident's Consent For Use of Psychotropic Medications" on 8/15/11 at 12:25 p.m., it indicated Seroquel was increased to 75 mg for dementia with behavioral problems. It was signed on 7/20/11 by the responsible party and the physician. During an interview on 8/15/11 at 12 noon, licensed nurse C (LN C) stated Resident 13's Seroquel dose should be 75 mg when she compared the physician's order to the medication administration Record (MAR). During review on 8/15/11 at 12:05 p.m. of the Medication Administration Record (MAR) for August 2011, it indicated Seroquel 50 mg was administered to Resident 13 every evening from August 1 through August 14, 2011. Review of August MAR on 8/15/11 at 3:40 p.m. indicated Resident 13 was monitored and exhibited approximately 42 behaviors of "yelling" and "screaming for no apparent reason . . ." from August 1 through August 14, 2011.	F 309	The Director of Nursing or designee will perform random check on three (3) residents daily to ensure pain assessment is completed before and after pain medications. The Director of Staff Development or Registered Dietitian or designee will observe meal times daily and assess CNA's knowledge on accuracy of calculating residents meal intake by random oral quiz. Issues on non compliance will be brought to the attention of the responsible staff for immediate resolution. Quality Assurance Committee will meet monthly to track, trend and for further resolution of non compliance. • Dates when corrective action will be completed: 09/30/2011	9/30/11 and on going 9/30/2011

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F 309	Continued From page 32 During record review on 8/17/11 at 8:10 a.m., "Licensed Nurse Weekly Summary" dated 8/12/11 indicated Resident 13 had episodes of yelling and screaming with no apparent reason. During review on 8/19/11 at 10:30 a.m., the facility's undated policy and procedure, "Administration of Drugs" indicated medications must be administered in accordance with the written orders of the attending physician. 6. Resident 8 was admitted to the facility with diagnoses including multiple sclerosis (progressive disease that damaged the nerves). A Minimum Data Set (MDS, an assessment tool) dated 7/27/11 indicated Resident 8 was moderately impaired in cognitive skills with decision making. During initial tour observation on 8/15/11 at 8:30 a.m., Resident 8 was resting in bed, awake and alert. Resident 8 wore a boot on her left leg due to a stage two (layer of the skin is broken, creating a shallow open sore) left heel pressure ulcer. A record review was done on 8/15/11. On 12/24/10 at 2 p.m., a physician order indicated to give Norco 5/325 milligrams (mg) one tablet PO every four hours for moderate pain" and two tablets (tabs) for severe pain. A "Nurse's medication notes" indicated Resident 8 received Norco 10/325 milligrams for pain on 3/12/11, 3/13/11, 3/18/11, 3/24/11, 3/26/11, 4/26/11, 5/1/11, and 5/24/11 for pain level six out of ten with ten being the worst pain.	F 309		

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F 309	Continued From page 33 There was no documentation in the record indicating Resident 8 was reassessed for pain after receiving Norco. During interview on 8/16/11 at 10:50 a.m., licensed nurse C (LN C) stated the resident's level of pain should be assessed before and after giving medication using the pain scale. 7. A review of record indicated on 1/5/11 the physician ordered to give Morphine Sulfate 30 mgs SR (sustained release) every 12 hours. The Medication Administration Records indicated Resident 8 received Morphine Sulfate 30 mgs every 12 hours daily between December 2010 through June 21, 2011. Resident 8 went to the acute care hospital and returned on June 29, 2011 without any orders for Morphine. During interview on 8/22/11 at 9:28 a.m., licensed nurse D (LN D) stated Resident 8 had a left heel wound, but she had no pain on assessment when she was readmitted to the facility. During interview on the same date at 11:00 a.m., the director of nurses (DON) reviewed the record and stated Resident 8 did not have any orders for Morphine for the month of July 2011. She stated "It might have been discontinued at the hospital." The DON reviewed the records and stated she could not find any documented evidence indicating when the morphine was discontinued in the hospital. She stated the licensed nurses did not call to clarify the orders for morphine when Resident 8 was readmitted to the facility on 6/29/11 because she was "Stable."	F 309		

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F 309	Continued From page 34 However, on 8/15/11 when the DON was apprised that a 7/11 MAR indicated Resident 8 had not received any pain medication since July, staff later received a physician order for PRN (when necessary) pain medication. They later medicated Resident 8 with Norco 5/325 mgs for a pain level of 5 out of 10. The facility's undated policy and procedure "Resident rights: pain management" indicated a resident's pain should be evaluated using a pain scale of zero to 10 (zero was no pain, 1-3 indicated mild pain, 4-6 indicated moderate pain, and 7-10 indicated severe pain). The policy further indicated it was important to note what pain level was considered acceptable for the resident. 8. Resident 2 was admitted to the facility with diagnoses including congestive heart failure (CHF, the heart can no longer pump enough blood to the rest of the body) and acute kidney failure (sudden loss of the ability of the kidneys to remove waste from the body). The Minimum Data Set (MDS, an assessment tool) dated 6/9/11 indicated Resident 2 had modified independence in cognitive skills for daily decision making. The clinical record for Resident 2 was reviewed on 8/16/11. The Weight Variance Team Evaluation dated 8/4/11 indicated Resident 2 was recently admitted to the acute care hospital for CHF exacerbation (increase in severity) and had returned to the facility on 7/29/11. The Weekly Weights Record indicated Resident 2's weight was 177 pounds (lbs) on 7/30/11, 179 lbs. on 8/6/11 and 165.9 lbs on 8/13/11. There was a 13.1 lb weight loss in one week from 8/6/11 to	F 309		

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F 309	Continued From page 35 8/13/11. During an interview with the registered dietician (RD) on 8/16/11 at 10:40 a.m., she stated resident weekly weights were usually done on Saturday and placed in the folder for the RD to review when she came to the facility. She stated she reviewed the Weekly Weight Record and found Resident 2 had a weight of 165.9 on 8/13/11 indicating the resident lost 13.1 pounds in one week. She stated she had Resident 2 reweighed and the resident's weight was 167.5 on 8/15/11 indicating a significant weight loss of 11 pounds in one week. During an interview and record review with the ADON on 8/16/11 at 11:20 a.m., she stated weekly weights were done on Saturdays by the restorative nurse assistant (RNA) and documented on the Weekly Weight Record for the RD to review when she came in to assess residents. She stated when the RNA finished weighing the resident and there was a change in the resident's weight the RNA should notify the nurse and the nurse should have the resident reweighed. Once the resident is reweighed, the physician and responsible party should be notified and it should be documented on the resident's clinical record. She also stated there was no documentation indicating Resident 2 had been reweighed. For this same resident, the physician's order dated 6/19/11 indicated to monitor left and right lower extremity edema (swelling) every shift and notify medical doctor of any changes. The Physician's Progress Note dated 7/31/11	F 309		

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F 309	Continued From page 36 indicated Resident 2 had 2-3 plus pedal bilateral edema (swelling in the feet and ankles) and "can go very quickly from fluid overload to acute renal failure". Continue the same medications, but must keep close eye on Lasix (medication used to reduce accumulation of excess fluid) dose and monitor. The Treatment Record dated 8/1/11 to 8/16/11 indicated only the nurse's initial for the every shift monitoring for the left and right lower extremity edema, no documentation of the actual amount of edema (swelling). During an observation and interview with Resident 2 on 8/16/11 at 3:15 p.m., she was in her room in bed with a pillow under her feet. She stated her "legs were smaller in size than before." During an interview and record review with licensed nurse D (LN D) on 8/17/11 at 7:30 a.m., she stated when monitoring for edema in the lower extremities the nurse should document the level of edema by using a scale of 1 plus (small amount of fluid), 2 plus (mild accumulation of fluid), 3 plus (moderate amount of fluid), and 4 plus (severe accumulation of fluid) on the Treatment Record, weekly summary or the nurse's notes. She stated the nurse's notes and weekly summary did not indicate Resident 2's edema was checked every shift and the Treatment Record only had a nurse's initial indicating the edema was monitored every shift. She stated one would need to know the level of edema to indicate if there was a change in the resident's edema and to notify the physician as ordered. She also stated there was no documented evidence on Resident 2's record	F 309		

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F 309	Continued From page 37 indicating the physician and responsible party were notified of any changes. During an interview and record review with licensed nurse E (LN E) on 8/19/11 at 7:15 a.m., she stated Resident 2's edema had gone from a 3 plus to a 2 plus but she had not notified the physician of the change as ordered and there was no documentation indicating the physician or responsible party were notified by any nursing shift as ordered. She stated she was aware of the significant weight loss on 8/13/11, but she did not have Resident 2 reweighed. The facility's undated policy and procedure, "Edema", indicated to assess resident with edema by applying pressure using fingers on the swollen area, an indentation will appear and remain for about 10-15 seconds. The licensed nurse was to use a scale of 1 plus (trace edema), 2 plus (mild edema), 3 plus (moderate edema) and 4 plus (severe edema). The licensed nurse will document assessments in the treatment administration record (TAR) using the scale listed. The licensed nurse will notify attending physician of any significant changes in edema. 8. Resident 16 was admitted to the facility with diagnoses including chronic renal (kidney) failure and end stage renal disease. The MDS dated 6/5/11 indicated Resident 16 was independent in cognitive skills for daily decision making and was receiving hemodialysis (method used to remove waste products from the blood) every Monday, Wednesday and Friday. The clinical record for Resident 16 was reviewed on 8/18/1. The physician's order dated 11/8/10	F 309		

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F 309	Continued From page 38 indicated Epogen 1800 units (medication used to treat anemia in people with chronic renal disease) intravenous push three times a week, give at dialysis. During an interview and record review with licensed nurse H (LN H) on 8/18/11 at 3:25 p.m., she stated communication between the dialysis center and the facility was done by using a dialysis communication form. She stated if medication was to be given at the dialysis center it should be documented as given by the dialysis center on the communication form and the form should be returned to the facility with the resident. She stated the dialysis center should document on the communication form any changes the resident might have had during the dialysis treatment, and the pre and post dialysis weight and vital signs. She stated on 8/5/11, 8/10/11 and 8/12/11 the dialysis center did not indicate if the Epogen was given as ordered and the facility nurse should have called the dialysis center to make sure the medication was given. She also stated on 8/10/11 there was no documented communication from the dialysis center and the facility nurse should have contacted the dialysis center for information. The facility policy and procedure, "Dialysis, Coordination of Care and Assessment of Resident" dated 7/08, indicated the Dialysis Center, by telephone or in writing, will notify the facility of the following: The resident's vital signs and weight after dialysis. Any medications given during dialysis care.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	F329-D DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	09/30/11

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F 329	Continued From page 39 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure three of 24 sampled residents did not receive unnecessary medications (8, 15, and 22). Resident 8 received an excess dose of Norco for six months when Resident 8 received Norco 10/325 (a narcotic pain medication mixed with Tylenol 325 milligrams (mg)) instead of Norco 5/325 between December 2010 and August 2011. For Resident 15 there was no indication for the use of	F 329	• How corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Resident 8 Norco order was discontinued on 07/23/2011 and reinstated on 08/15/2011 with the correct dosage as confirmed by two (2) Licensed Nurses on 08/15/2011. The attending Physician and Responsible Party were notified on 09/09/2011 by the Director of Nursing regarding the dosage of Norco administered to resident on 01/28/2011, 03/05/2011, 03/06/2011, 03/12/2011, 03/13/2011, 03/18/2011, 03/24/2011, 03/26/2011, 03/30/2011, 04/22/2011, 05/01/2011, 05/11/2011, 05/12/2011, 05/21/2011, 05/24/2011, 06/15/2011, 06/19/2011. 2. The Resident's 15 order of Nortriptyline was clarified from the attending Physician on 08/17/011 at 4PM regarding indication of use and monitoring side effects. First dose of Nortriptyline was administered 08/17/2011 at 9PM. 3. The Resident's 22 is no longer in the facility.	09/30/11

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F 329	Continued From page 40 Nortriptyline in the physician's order per facility policy and no adequate monitoring for the use of the medication. For Resident 22 there was no indication for the use of two medications, certriptyline (a medication used for allergies) and anagrelide (a medication used to decrease the risk of blood clots) in the physician's order per facility policy. Findings: 1. Resident 8 was admitted to the facility with diagnoses including multiple sclerosis (progressive disease that damaged the nerves). Resident 8's Minimum Data Set (MDS, an assessment tool) dated 7/27/11 indicated Resident 8 was moderately impaired in cognitive skills for daily decision making. During an observation on 8/15/11 at 8:30 a.m., Resident 8 was resting in bed, awake and alert. She responded slowly to questions and her speech was not clear. The clinical record for Resident 8 was reviewed on 8/15/11. On 12/24/10 at 5 p.m., a physician ordered give Norco 5/325 mg" one tablet PO every four hours for moderate pain and two tablets (tabs) for severe pain. A record review of the MAR and "Individual Patient's Administration Record" indicated on the following dates: 1/28/11, 3/2/11, 3/5/11, 3/6/11, 3/12/11, 3/13/11, 3/18/11, 3/24/11, 3/26/11, 3/30/11, 4/22/11, 5/1/11, 5/11/11, 5/21/11, 5/24/11, 6/15/11, and 6/19/11 staff removed and administered Norco 10/325 mg (instead of 5/325 mg) and inaccurately documented on the MAR	F 329	• How the facility will identify other resident having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Director of Nursing, Assistant Director of Nursing, Director of Staff Development and MDS Coordinators conducted an audit on August 17, 19 and 21, 2011 on all residents on narcotic to ensure that stock medication on hand matches Physician's order and each narcotic medication are accountable for by signing both medication form record and controlled drug record. 2. The Pharmacy Nurse Consultant conducted three (3) way audit on all residents medication beginning 09/07/2011, 09/08/2011 and 09/11/2011 to ensure presence of indication of medications and correct medication stock on hand are accountability for each medications. • What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	

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F 329	Continued From page 41 they gave 5/325 mg of Norco. On 5/12/11 Resident 8 received two Norco 10/325 mg tablets at 5 p.m. Staff continued to administer the excess dose of Norco to Resident 8. During an interview on 8/16/11 at 3:50 p.m., the assistant director of nurses (ADON) reviewed the records and stated she could not explain what happened. She acknowledged that staff were giving the wrong dosage to Resident 8. She stated "This should not happen." During an interview on 8/17/11 at 10:37 a.m., the director of nurses (DON) stated staff are responsible to ensure residents received the right prescribed dose of medication. During an interview on 8/16/11 at 4:18 p.m., the registered pharmacist A (RPH A) stated nurses were responsible for administering the right dose of medication to Resident 8. During an interview on 8/17/11 at 11:40 a.m., RPH B stated he was concerned staff were not administering Norco as prescribed by the physician. 2. Resident 15 was admitted to the facility with diagnoses including peripheral neuropathy (damage to nerves of the peripheral [arms and legs] nervous system) and depression. The MDS dated 5/6/11 indicated Resident 15 was independent in cognitive skills for daily decision making and had three to four episodes of pain in her hands and legs. The clinical record for Resident 15 was reviewed	F 329	1. The Licensed Nurse shall confirm medication received from pharmacy by checking Medication Administration Record each time delivery arrived prior to stocking medication in the medication cart. Controlled medication will be confirmed by two (2) Licensed Nurse. For Quality Assurance to audit. 2. During shift endorsement of controlled medication by the incoming and outgoing Licensed Nurse: The incoming Licensed Nurse will confirm the Medication Administration Record with each narcotic medication that were logged out by the outgoing shift. 3. The Director of Nursing conducted in service to Licensed Nursing staff beginning 08/21/2011 and ongoing regarding indication of use with each medication, compliance in implementing the facility's policy and procedure on "Administration of Drugs" Topic include the role of the Licensed Nurse in administering medication to ensure that the right resident, medication, dosage, time, route, indication and additional information for as needed, medication must include complaint/symptoms and results must be noted and signed by the administering nurse.	

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SAN TOMAS CONVALESCENT HOSPITAL	3580 PAYNE AVENUE SAN JOSE, CA 95117

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F 329	Continued From page 42 on 8/18/11. The neurology physician's order dated 8/16/11 indicated Nortriptyline 10 milligram (mg) tablet by mouth (po) every (q) night for one week, then two tablets po q night for one week, then three tablets po q night. There was no documented evidence of an indication for the use of the medication. The Medication Administration Record (MAR) dated 8/16/11 to 8/22/11 indicated Resident 15 received the Nortriptyline as ordered. There was no indication for the use of the medication and no adequate monitoring for side effects of the Nortriptyline documented. During an interview and record review with licensed nurse D on 8/18/11 at 3:10 p.m., she stated the order for the Nortriptyline was written by the neurologist and the medication was prescribed for the resident's pain. She also stated she was not aware of the side effects of the Nortriptyline, so she did not know what to monitor in the resident receiving the medication. The facility policy and procedure titled "Medication Orders" indicated, "When recording orders for medications...also include diagnosis or reason for medication." A physician's order dated 8/15/11 indicated Resident 22 was to receive cetirizine (used for allergies) 2.5 mg (milligrams) by mouth daily per patients request. No diagnosis or indication was listed for this medication. A physician's order dated 8/15/11 indicated Resident 22 was to receive anagrelide	F 329	This in service also included comparing stock medication on hand and physician order prior to administering medication and to signed off in controlled drug log and medication administration record. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: 1. The Pharmacy consultant will continue to do monthly medication review to ensure presence of medication of use for each narcotic are administered as ordered by Physicians. Findings will be given to Administrator and Director of Nursing. 2. The Pharmacy consultant nurse will conduct a quarterly three way audit on stock medication and Physicians orders. Findings will be given to the Administrator and Director of Nursing. For QA to audit. 3. The Director of Nursing or designee will do a daily two (2) random medication audit to ensure that medications are given as ordered and correct medications are on hand by observation during medication pass. For QA to audit.	

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F 329	Continued From page 43 (medication used to reduce the risk of a blood clot) (0.5 mg) by mouth twice a day. No diagnosis or indication was listed for this medication. During record review on 8/17/11 at 9:55 a.m. of Resident 22's medication administration record (MAR) dated August 2011, it indicated there was no reason or diagnosis for the above medications, cetirizine and anagrelide. During an interview on 8/18/11 at 9:30 a.m. licensed nurse G (LN G) reviewed Resident 22's above medications listed on the MAR. She stated she was "not sure" what medical diagnosis cetirizine or anagrelide were used for. Review of policy and procedure "Medication Orders" on 8/19/11 at 10:30 a.m. indicated, "When recording orders for medication...also include diagnosis or reason for medication."	F 329	4. Any issued of non compliance will be brought to the attention of Quality Assurance Committee on monthly basis for tracking, trending and resolution. • Dates when corrective action will be completed: 09/30/2011	
F 361 SS=D	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	F 361	F361 QUALIFIED DIETITIAN- DIRECTOR OF FOOD SERVICES The facility must ensure that all Residents that are readmitted after a change of condition must be re-evaluated by a qualified Registered Dietitian and complete a dietary comprehensive assessment to include calorie, protein and fluid needs. 1. Corrective Actions: A. Resident 8 was reassessed by qualified Registered Dietitian on 09/08/2011 that include calorie, protein and fluid needs calculation.	09/30/11

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F 361	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a registered dietician (RD) conducted a nutritional assessment for one of 24 sampled residents (8). Resident 8 was readmitted to the facility after receiving a blood transfusion. This failure may result in late identification of residents' potential nutritional problems. Findings: Resident 8 was admitted to the facility with diagnoses including anemia (low red blood cell level) and dysphagia (difficulty swallowing). A Minimum Data Set (MDS, an assessment tool) dated 7/27/11 indicated Resident 8 had moderately impaired cognitive skills with decision making. Record review of the 7/25/11 laboratory record indicated low hemoglobin and hematocrit levels (laboratory tests used to indicate anemia) of 11.0 and 34.1 respectively. A record review on 8/17/11 indicated the records lacked a comprehensive dietary assessment. During interview on 8/17/11 at 2:42 p.m., RD stated when residents were readmitted to the facility after a change in condition, a complete comprehensive assessment should be completed. RD stated her summary note did not include the required calories, protein and estimated fluid needs for Resident 8. She acknowledged that considering Resident 8 had a blood transfusion, a complete nutritional assessment was important to know if additional	F 361	B. All readmitted residents with change of condition should be re-evaluated by a Registered Dietitian using a comprehensive Nutritional assessment to include estimated calorie, protein and fluid needs within 14 days of readmission. C. A care plan will also be developed to include problems, measurable goals, and interventions. D. The Registered Dietitian will determine the Ideal Body Weight (IBW) using the HAMWI Method: Men: 106 lbs for the first 5 feet, 6 lbs every inch thereafter Women: 100 lbs for the first 5 feet, 5 lbs for every inch thereafter E. The Registered Dietitian will address all aspects of nutrition including Biochemical parameters as available, Resident's behavior, eating patterns, food preferences through data collected from Interdisciplinary Team observations and interviews if applicable during nutritional assessments. 2. How to identify other Residents: All Residents that have been readmitted with a change of condition will be discussed in the daily stand-up meeting.	

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F 361	Continued From page 45 calories and proteins was needed. A facility's undated policy and procedure "Nutritional assessment" indicated the RD should evaluate the resident's nutritional status and develop a plan suitable for his/her nutritional needs.	F 361	Likewise, the Registered Dietitian will initiate the comprehensive nutritional assessment within 14 days. (continued on continuation sheet)	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one resident (3) was provided substitute food for a mechanical soft fortified lactose free diet when she refused the food served. Failure to provide this has the potential to affect the nutritional needs of the resident as prescribed by the physician. Findings: Resident 3 was admitted to the facility with diagnoses including atrial fibrillation (irregular heart beat). The Minimum Data Set (MDS, an assessment tool for residents) dated 8/12/11 indicated Resident 3 was cognitively intact and independent in the activities of daily living. During record review on 8/15/11, the MDS indicated Resident 3 was on mechanical soft no added salt, no concentrated sweets fortified (added calories and protein) lactose free diet. During lunch observation and interview on	F 366	F366 SUBSTITUTES OF SIMILAR NUTRITIVE VALUE The facility will ensure that food substitutes of similar nutritive value will offered when food that is served is refused. 1. Corrective Action: An in service will be done for Nursing Staff and Dietary Staff on how to offer residents food substitutes if meals were refused. Identify what kinds of foods have similar nutritive values and familiarize with the list of foods available in the kitchen. 2. How to identify other Residents: The Certified Nursing Assistant will identify residents with chronic or habitual pattern of changing their meals with substitutes and refer for Registered Dietitian consult to better an in-depth assessment of food preferences. 3. Systemic Changes: The Dietary Department will include in the list of food items and purchase food	09/30/11

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F 361	continued from page 46.	F 361	(continued from page 46) 3. Systemic Changes: The Registered Dietitian will be made aware of all admission and readmission thru an internal communication system called ADMISSIONS, DISCHARGES AND ROOM CHANGES MEMO. Such MEMO will be placed in a designated place in the business office. 4. Monitoring Process: The Medical Records staff will do a monthly Audit of Readmitted Residents with change of condition to check if a comprehensive nutrition assessment was done. Issues on non compliance will be brought to the attention of Administrator and discussed with Quality Assurance Committee during monthly meeting. 5. Date of Completion: 09/30/2011 SEP 19 2011	09/30/11

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F 366	Continued From page 46 8/15/11 at 12:45 p.m., Resident 3 stated she only ate the chicken soup, half banana and a piece of bread. She did not like the rest of the food served. The cut broccoli, turkey, and corn were not touched. During an interview with the registered dietician (RD) on 8/15/11 at 4:25 p.m., RD stated the fortified juice would add 200 calories. No substitute for the lactose restriction was served. The facility's Diet Manual dated 2009 indicated residents with poor appetite who eat less than 75% of meals usually benefit from more nutrient dense foods served at meal times rather than between meal snacks and supplement. If Protein Powder Mix is added, it can add an additional 120 kcal (calories), 12grams of protein per serving or can be substituted for the milk products in a lactose free diet (1/4/C (cup) of mix per serving).	F 366	additions like Multi-Mix or Protein Powder Mix to add to food items to make it more dense in calories and proteins especially for limiting diets such as "lactose free" diets where in most supplements are dairy based. 4. Monitoring Process: The Nursing Staff will be monitored for comprehension of the topic of foods with similar nutritive value by random checking by Director of Staff Development during rounds and periodic evaluation tests given by Registered Dietitian and Director of Staff Development. 5. Completion Date: 09/30/2011	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a	F 368	F368 FREQUENCY OF MEALS/SNACKS AT BEDTIME The facility will ensure that all residents will be offered snacks at bedtime daily and that no more than 14 hours will be between a substantial evening meal and breakfast the following day. 1. Corrective Action: All residents will be offered an evening snack between 7pm to 9pm consists of milk, juice, crackers or cookies in bulk.	09/30/11

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F 368	Continued From page 47 nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure bedtime snacks were offered to 12 non-sampled residents. Findings: During a confidential interview on 8/16/11 at 1 p.m., 12 of 12 non sampled residents stated they were not offered snacks in the evening. They stated snacks such as juice, graham crackers and sandwiches were delivered to the stations, but they had to ask for the snack if a snack arrived without their name on it. During an interview with certified nurse assistant N (CNA N) on 8/18/11 at 2:55 p.m., he stated evening snacks were usually delivered between 6 and 6:30 p.m. He stated the snacks delivered usually had a resident's name on the snack and the snacks were given to the resident. He also stated evening snacks were not offered to other residents and if they wanted a snack the resident must ask for the snack. During an interview with licensed nurse H (LN H) on 8/18/11 at 3:25 p.m., she stated bedtime snacks usually were delivered with the resident's name on the snack and were delivered to that specific resident. She stated extra snacks usually came at the same time and the resident could ask for a snack. The facility policy and procedure,"Supplement/Snack Procedures for	F 368	Each Certified Nursing Assistant assigned to their respective residents will offer evening snacks as part of their daily routine. 2. How to identify other residents: All Certified Nursing Assistant will offer evening snacks as part of their routine when taking care of residents in the PM shifts. Each Certified Nursing Assistant will be responsible for their daily assigned residents. 3. Systemic Changes: An in service to all PM CNAs and Licensed staff will be done to re-enforce facility's policy of offering evening snacks to all residents. Dietary will likewise provide a variety of cookies, crackers and beverages to include milk, juice or hot beverages such as cocoa or tea to be delivered on each Nursing Station. It will be the responsibility of Nursing Staff to offer their respective residents and will document in the ADL flow sheet. 4. Monitoring Process: The Director Staff Development will do a random check on compliance of Nursing Staff in offering evening snacks to their respective residents by interviewing alert residents randomly during rounds. During the Resident Council Meeting every	

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F 368	Continued From page 48 NA/CNA" dated 9/08, indicated hour of sleep supplements/snacks must be offered to all residents each evening. Each evening, dietary will provide milk, punch, crackers and graham crackers in bulk to be offered to all the residents.	F 368	month, the President of the resident council will include in the agenda if evening snacks had been consistently offered daily. 5. Date of Completion: 09/30/2011	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 and interview, the facility failed to store food and serve food under sanitary condition as evidenced by handwashing water sprayed onto sanitized dishwares (utensils and serving trays), a file of uncleanable plastic serving trays in the clean cart, a tray full of frozen 6 ounces of juice in a carton packages with no label outside the refrigerator, 2 bags of corn meal, one open and one unopened inside the bin, rusty shelves not cleanable in the dry storage room, one shelf was not at least 6 inches from the floor and was dirty underneath, food stored at the resident bedside was undated and a slice of buttermilk cake had small blue-green spots. These failures had the potential to result in foodborne illnesses among residents who were at risk of serious complications from foodborne	F 371	F 371 FOOD PROCURE, STORE, PREPARE/SERVE- SANITARY The facility must ensure that food will be procured from sources approved or considered satisfactory by the Federal State or local authorities, and store, prepare, distribute and serve food under sanitary conditions: 1. Corrective Action: The facility will do or have already done corrective actions on the following: A. Handwashing sink will be segregated from shelves of clean utensils by putting up a barrier that is flat and cleanable to disinfect surface. This will prevent handwashing water sprayed onto clean utensils. B. No frozen drink or any food will thawed outside the refrigerator at all times. All items will be properly labeled and dated. C. No bag or container of food will be placed inside a storage bin. Food items such as corn meal, flour, rice, etc will be	09/30/11

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F 371	Continued From page 49 illnesses. Findings: 1. During observations on the initial tour on 8/15/11 at 7:40 a.m. in the kitchen, the sink was close to the cart of cleaned and sanitized dishwares. Water sprayed over the utensils during handwashing. There was no barrier to protect the clean dishwares. During an interview with the registered dietician (RD) on 8/15/11 at 8:05 a.m., RD stated the facility was going to place a plastic barrier to prevent water from spraying on the clean dishwares. Serving plastic trays in the clean cart were observed to have sharp and rough edges which were not cleanable. The RD stated the facility had ordered new trays to replace the old ones. During the same observation tour a full tray of unlabeled frozen 6 ounces of juice in carton packages were found outside the door of the walk-in refrigerator. During an interview with dietary aide 1 (DA 1) on 8/15/11 8:10 a.m., DA 1 stated he was thawing the juice cartons and did not know the time when the juices were taken out of the freezer. 2. During an observation in the dry storage room on 8/16/11 at 8:05 a.m. two bags of corn meal were inside the bin; one open and the other was not. During an interview with RD on 8/16/11 at 8:05 a.m., she stated dietary aides did not remove the powdered corn meal from their original container.	F 371	poured into clean storage bins and closed properly to avoid being contaminated. D. All shelves in the dry storage area have been elevated to at least 6 inches up from the floor. Floors underneath have been cleaned. E. All food items brought in by family at Resident's bedside will be thrown away after 3 days. CNAs will put a date when it was first brought into the facility and likewise dispose of food item after 3 days. F. The facility have already replaced on 09/09/2011 the plastic trays used for distributing meals at 100%. All old trays with exposed and rough corners had been disposed. G. The two shelves in the dry storage with uncleanable rust will be replaced. 2. How to identify other residents: The CNAs will identify their respective residents with foods at the bedside and secure a clear plastic container to store shelf stable food only. Unopened food in their original packages will be allowed, but foods that have been opened will be dated and labeled and disposed of after 3 days. This will be strictly complied to by all CNA. 3. Systemic Changes: An in service for Nursing staff will conducted by Director of Staff Development and Registered Dietitian regarding safe food handling especially	

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F 371	Continued From page 50 3. One shelf inside the dry storage room was not 6 inches above the floor and underneath was dirty and hard to clean. Two shelves were rusty and uncleanable. During an interview with the RD at 9 a.m. on 8/16/11, she stated the facility should fix it. The facility's policy and procedure dated 2008, "Food Service Management" indicated, opened dry staples such as flour and sugar are stored in labeled containers of corrosion-resistant materials with tight fitting lids. Original packaging materials should be removed. Portable bins or dollies are recommended. 4. On 8/15/11 at 8:10 a.m. during the initial tour and interview with licensed nurse I (LN I) an opened, see through, plastic container was observed at the bedside in Room 206. The see through plastic container had four slices of buttermilk cake. One cake slice cake had three small blue-green spots located in the middle of the slice. There was no date listed on the see through plastic container. During an interview with LN I on the same date and time, she stated the resident's family often brought sweets for the resident and she did not know how long the cake had been at the bedside or how long it had been opened. The facility policy and procedure, "Food Brought Into Facility By Visitors " dated 9/08, indicated food brought into the facility for resident consumption will be labeled and dated for monitoring food safety.	F 371	for bedside foods brought in by families for their loved ones in the facility. An in service will be done by Registered Dietitian for Dietary staff regarding: • Proper thawing of frozen drinks • Cover, date and label policy • How to properly store foods in storage bins Maintenance will inspect all shelves in the storeroom for signs of unremovable rust and replace immediately. Maintenance will put up a flat and cleanable surface in the handwashing sink area to prevent water spray from contaminating clean and sanitized utensils. 4. Monitoring Process: Director of Staff Development and Registered Dietitian will report in the Quality Assurance Committee meeting every quarter of the progress on the completion and compliance to plan of correction of the above mentioned concerns. 5. Date of Completion: 09/30/2011	

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F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that garbage and refuse were properly disposed and maintained in sanitary condition when two overflowing trash dumpsters had an open lid and 10 garbage bags around the dumpsters were found. This failure had the potential of infestation and pest harborage resulting in possible transmission of disease in the facility. Findings: During the first day of the survey on 8/15/11 at 7:30a.m., outside the facility were 10 garbage bags around two overflowing trash dumpsters with an opened cover. During an interview with the maintenance supervisor (MS) on 8/15/11 at 3:25 p.m., MS stated seldom that the garbage was full. Garbage pick ups were Monday, Tuesday and Friday, no pick ups on weekends. He stated dumpsters should be covered and no garbage bags should be on the ground.	F 372	F 372 DISPOSE GARBAGE & REFUSE PROPERLY The facility will dispose of garbage and refuse properly. 1. Corrective Action: The facility added extra day of garbage collection every Saturday beginning 09/03/2011. The maintenance crew will ensure that garbage will not be placed on the ground in case of emergent situations such as failure of garbage truck to collect. Instead, maintenance will have a temporary closed bin available for overnight garbage. 2. How to identify other residents: The facility will anticipate increase in garbage volume according to number of census of residents and also anticipate garbage volume for special occasions that require celebration with food. The facility will request for an extra pick up day in anticipation of large garbage volume. (continued on continuation sheet)	09/30/11
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	F 425	F 425 PHARMACEUTICAL SERVICE	09/30/11

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SAN TOMAS CONVALESCENT HOSPITAL	3580 PAYNE AVENUE SAN JOSE, CA 95117

(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
F372	continued from page 52.	F372	(continued from page 52) 3. Systemic Changes: The facility will assign maintenance to oversee garbage disposal and avoid littering trash around dumpster area. An extra pick-up day on the weekend will be done to avoid pile up of trash on Mondays. The following Departments: Dietary, Housekeeping and Maintenance will take turns in monitoring garbage overflow and ensure that lids are in place and covering dumpsters at all times. 4. Monitoring Process: The Administrator or designee will inspect dumpsters every morning to ensure it is covered and no garbage on the floor and findings will be discussed in the morning stand up meeting for quality assurance audit. Issues on non compliance will be brought up with the Quality Assurance Committee during monthly meeting for further trending, tracking and resolution. 5. Date of Completion: 09/30/2011	09/30/11

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F 425	Continued From page 52 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately acquire and administer the correct dose of Norco (a narcotic pain medication mixed with Tylenol 325 milligrams (mg)) for one of 24 sampled residents (8) when the facility received Norco 10/325 instead of Norco 5/325 from the pharmacy. The licensed nurses administered the Norco 10/325 instead of Norco 5/325 which was ordered by the physician. The facility also failed to ensure the emergency drug box use log was updated when an antibiotic was removed from the emergency drug supply. It is important for a log to be kept of all drugs removed from the locked emergency storage box because there needs to be a system of accountability of all drugs. Findings: 1. Resident 8 was admitted to the facility with	F 425	• How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Resident's 8 Norco order was discontinued on 07/23/2011 and restarted on 08/15/2011 with correct dosage. The Registered Pharmacy Consultant conducted on monthly drug regimen review for Resident 8 on 08/25/2011 and checked current Norco order and stock of medication. 2. The emergency drug log was immediately updated on 08/15/2011 by Licensed Nurse Z. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Registered Pharmacy Consultant conducted a monthly drug regimen review to all residents on 08/25/2011 and 08/26/2011.	

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F 425	Continued From page 53 diagnoses including multiple sclerosis (progressive disease that damaged the nerves). The Minimum Data Set (MDS, an assessment tool) dated 7/27/11 indicated Resident 8 was moderately impaired in cognitive skills for daily decision making. The clinical record for Resident 8 was reviewed on 8/15/11. On 12/24/10 at 2 p.m., a physician ordered Norco 10/325 mg one tablet by mouth (PO) every four hours when necessary for severe pain and Norco 5/325 mg one tablet PO every four hours when necessary for moderate pain. On the same day at 5 p.m., the above order was clarified with the physician to give Norco 5/325 mg one tablet PO every four hours for moderate pain and two tablets (tabs) for severe pain. The Manifest Receipt between 12/25/10 and 6/30/11 indicated the facility received Norco 10/325 mgs instead of Norco 5/325 mgs from the pharmacy. Resident 8's medication administration record (MAR) indicated on 1/28/11, 3/2/11, 3/5/11, 3/6/11, 3/12/11, 3/13/11, 3/18/11, 3/24/11, 3/26/11, 3/30/11, 4/22/11, 5/1/11, 5/11/11, 5/12/11, 5/21/11, 5/24/11, 6/15/11, and 6/19/11 staff administered Norco 10/325 mg instead of Norco 5/325 mg. The pharmacy dispensed 10/325 mgs Norco for Resident 8 on 12/25/10 after the order was clarified on 12/24/10 at 5 p.m. The pharmacist conducted monthly drug review between 1/11 through 7/11 and did not identify the change in	F 425	2. The Nursing Supervisor inspected all Emergency kit log on 08/15/2011 to ensure medications are logged out on timely manner. 3. The Director of Nursing conducted in service regarding importance of using Emergency drug kit log each time medication is pulls out of the box on 08/29/2011. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Registered Pharmacy Consultant was replaced beginning September 1, 2011. The new Registered Pharmacy Consultant will conduct monthly medication review to all residents Report of findings and recommendation will be given to the Administrator and Director of Nursing for review and follow-up. 2. The Nursing Supervisor will check all emergency drug log and kit on daily basis to ensure compliance. For Quality Assurance to audit.	

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F 425	Continued From page 54 the physician orders and also that the facility had acquired Norco 10/325 instead of 5/325 from the pharmacy. During an interview on 8/16/11 at 3:50 p.m., the assistant director of nurses (ADON) reviewed both the narcotic record and the medication administration reord and stated "This should not happen." During an interview on the same date at 10:37 a.m., director of nurses (DON) stated the Norco 10/325 should have been removed from the narcotic box when the order was changed. During interview on 8/23/11 at 10:27 a.m., registered pharmacist B (RPH B) stated when the physician changed the order on 12/24/10 at 5 p.m., the nurses should have pulled the 10/325 mg Norco from the narcotic box. The facility's policy and procedure, "Controlled Substances" dated 10/07, indicated the consultant pharmacist, or designee, provides pharmaceutical care services including, communicating to the responsible prescriber and the DON potential or actual problems detected and other findings related to medication therapy orders at least monthly. 2. During a drug storage observation on 8/15/11 at 8:16 a.m. a drug emergency storage box was noted stored inside station one medication storage room. During an interview on the same date and time, licensed nurse Z (LN Z) stated she had opened the box earlier in the day to remove an antibiotic for a resident. During record review shortly thereafter the emergency drug box use log	F 425	• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Nursing/ Administrator will review Registered Pharmacy Nurse report on monthly basis. The Director of Nursing or designee shall perform emergency kit box and log check 3x per week to ensure compliance. Issues on non compliance will be addressed to the Quality Assurance Committee during the monthly meeting to track, trend and further resolution. • Dates when corrective action will be completed: 09/30/2011	

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F 425	Continued From page 55 had no indication regarding the antibiotic LN Z removed. During an interview and record review at the same time and place LN Z stated she forgot to sign out the antibiotic and should have signed out the medication on the log when she removed it from the storage box.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's pharmacist failed to identify and report an irregularity to the facility's director of nurses and the attending physician for one of 24 sampled residents (8) when Resident 8 received an excessive dose of Norco for six months. Resident 8 received Norco 10/325 mg (a narcotic pain medication mixed with Tylenol 325 milligrams (mg)) instead of Norco 5/325 between December 2010 and June 2011. Findings: Resident 8 was admitted to the facility with diagnoses including multiple sclerosis (progressive disease that damaged the nerves).	F 428	F 428 DRUG REGIMEN REVIEW • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Registered Pharmacy consultant conducted a drug regimen review for Resident 8 on 08/25/2011 with new recommendations to attending Physician. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The Pharmacy Nurse consultant conducted a three (3) way audit on all medications. This audit includes but not limited to accuracy of Physician's order, stock/ dosage of medications and cart inspections beginning 09/07/2011, 09/08/2011 and 09/09/2011.	09/30/11

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F 428	Continued From page 56 A Minimum Data Set (MDS, an assessment tool) dated 7/27/11 indicated Resident 8 was moderately impaired in cognitive skills for daily decision-making. A record review was done on 8/15/11.On 12/24/10 at 5 p.m., a physician ordered to give Norco 5/325 mg one tablet PO every four hours for moderate pain and two tablets (tabs) for severe pain. On the following days: 1/28/11, 3/2/11, 3/5/11, 3/6/11, 3/12/11, 3/13/11, 3/18/11, 3/24/11, 3/26/11, 3/30/11, 4/22/11, 5/1/11, 5/11/11, 5/12/11, 5/21/11, 5/24/11, 6/15/11, and 6/19/11 staff removed and administered Norco 10/325 mg and inaccurately documented they gave Norco 5/325 mg on the medication administration record (MAR). There was no documentation indicating the pharmacist (RPH) identified the facility had Norco 10/325 in stock but charted Norco 5/325. There was no indication the pharmacist identified any irregularity regarding the excessive dose of Norco administered to Resident 8. During interview on 8/17/11 at 10 a.m., a director of nurses (ADON) reviewed the records and stated she could not explain what happened. She acknowledged the licensed nurses gave the wrong dosage to the resident. She stated "This should not happen." During interview on the same date at 10:37 a.m., director of nurses (DON) stated staff are responsible for ensuring residents receive the right prescribed dose of medication. She stated	F 428	• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Pharmacy Nurse consultant will conduct three (3) way audit on quarterly basis on all stations. The Registered Pharmacy consultant will continue to do monthly drug required review and submit findings to Administrator and Director of Nursing. Any recommendations will be forwarded to resident's respective attending Physician. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Administrator and Director of Nursing will review Registered Pharmacy consultant report on monthly basis.	On going On going

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F 428	Continued From page 57 the pharmacist should have identified any medication problems during the monthly review. During interview on 8/16/11 at 4:18 p.m., registered pharmacist A (RPH A) stated there were so many residents receiving narcotics in the facility, therefore, it was difficult to review the MAR for all the residents during drug regimen review. The pharmacist conducted monthly drug review between 1/11 through 7/11 and did not identify the medication irregularities for Resident 8. During interview on 8/17/11 at 11:40 a.m., RPH B stated he was concerned staff were not administering Norco as prescribed by the doctor. During interview on 8/23/11 at 10:27 a.m., RPH 2 stated this was a medication error. A facility's 2007 policy and procedure "Consultant pharmacist services provider requirements" indicated the pharmacist should assist in the identification and evaluation of medication -related issues including prevention and reporting medication errors. A 10/07 facility's policy and procedure "Controlled substances" indicated the consultant pharmacist should ensure that staff handling the controlled medications complied with the state and federal regulations regarding controlled substances.	F 428	Issues of non compliance will be brought to the attention of Quality Assurance Committee during monthly meeting for trending, tracking and resolution. • Dates when corrective action will be completed: 09/30/2011	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	09/30/11

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F 431	Continued From page 58 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility pharmacist failed to ensure Norco (a narcotic pain medication mixed with Tylenol 325 milligrams (mg)), a controlled drug was accurately reconciled (a system of documenting the receipt and administration of a substance that	F 431	• How corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Director of Nursing conducted a 1:1 in service to licensed nurse on 08/21/2011, that failed to document in medication administration record for Resident 8. Topic includes the proper technique in documenting of medication administered to show accountability for each controlled medications for signing off in controlled drug log and medication administration record. 2. The Licensed Nurse that involved in administered 2 Percocet 5/325mg made a late entry in Resident's 26 controlled drug log on 08/17/2011. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Medical Records conducted an audit beginning August 17, 2011 and ongoing to ensure that each signed off narcotic are accountable.	

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F 431	Continued From page 59 has a high risk of potential abuse) for one of 24 sampled residents (8). The facility failed to ensure Percocet (a narcotic pain medication mixed with Tylenol 325 mg) for one non-sampled resident (26) was accurately reconciled. Norco 10/325 was signed out on the "Individual Patient's Narcotic Record" for Resident 8 on 14 different days. However, there was no indication on Resident 8's Medication Administration Record or nurses notes, Resident 8 received the medication and obtained subsequent pain relief. Findings: 1. Resident 8 was admitted to the facility with diagnoses including multiple sclerosis (progressive disease that damaged the nerves) and respiratory failure (condition in which not enough oxygen passes from your lungs into your blood). A Minimum Data Set (MDS, an assessment tool) dated 7/27/11, indicated Resident 8 had moderate cognitive impairment with decision making. A record review was done on 8/15/11. On 12/24/10 at 2 p.m., a physician ordered Norco (hydrocodone/acetaminophen) 10/325 mg one tablet by mouth (PO) every four hours when necessary for severe pain and Norco 5/325 mg one tablet PO every four hours when necessary for moderate pain. On the same day at 5 p.m., the above order was clarified to give Norco 5/325 mg one tablet PO every four hours for moderate pain and two tablets Norco 5/325 mg for severe pain. The controlled drug record indicated the facility had received the following from the pharmacist:	F 431	2. The Pharmacy Nurse consultant conducted three (3) way audits on 09/07/2011, 09/08/2011 and 09/09/2011. This audit includes but not limited to checking Physician's order, stock on hand and accountability. 3. The Pharmacy Consultant Manager conducted in service to licensed nursing staff regarding narcotic diversion on 09/15/2011. The Director of Nursing conducted in service to licensed nursing staff regarding accurate documentation of medication administered beginning 08/21/2011 and ongoing. • What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Medical Record staff will do daily audit on medication accountability (Monday – Friday) by matching narcotic sheet with the medication administration record. Drug endorsement of controlled medication by the incoming and outgoing licensed nurses: For Quality Assurance to audit. The Licensed Nurse will confirm in the medication administration record each narcotic medication that were logged out by the outgoing shift.	

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F 431	Continued From page 60 12/25/11-15 tabs of Norco 10/325 3/6/11-15 tabs of Norco 10/325 3/8/11-15 tabs of Norco 10/325 6/30/11-30 tabs of Norco 10/325 A review of the "Individual patient's narcotic record" on 8/16/11, indicated staff removed Norco 10/325 mg on the following days :1/12/11, 2/8/11, 2/26/11, 3/3/11, 3/7/11, 3/15/11, 3/30/11 ,4/16/11, 4/19/11, 6/13/11, 6/18/11, 8/6/11 and 8/8/11. However, there was no documented evidence on the Medication Administration Record (MAR) indicating Resident 8 received the medications on these days. Resident 8's controlled drug record for Norco 10/325 was reviewed with the assistant director of nurses (ADON) on 8/16/11 at 3:50 p.m. ADON stated the controlled drug record for Resident 8 did not reconcile with the MAR. During interview on the same date at 10:37 a.m., the director of nurses (DON) stated the controlled drug record for Resident 8 did not match with the MAR. During interview on 8/16/11 at 4:18 p.m., a licensed pharmacist A (RPH A) stated there were so many residents receiving narcotics in the facility, therefore, it was not possible for her to review the narcotic record log and MAR for all the residents at the facility. The pharmacist conducted monthly drug review between 1/11 through 7/11 and did not identify the irregularities between the narcotic record log and the resident's MAR. The facility's 2007 policy and procedure,	F 431	The Pharmacy consultant nurse will conduct quarterly three (3) way audit and findings will be given to the Administrator and Director of Nursing. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Nursing or designee will do daily two (2) random medication audit during medication pass to ensure that licensed nurses are compliant in signing off controlled drug log and medication administration record. For Quality Assurance to audit. Issues on non compliance will be brought to the attention of Quality Assurance Committee during morning meeting for tracking, trending and resolution. • Dates when corrective action will be completed: 09/30/2011	

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F 431	Continued From page 61 "Consultant pharmacist services provider requirements", indicated the pharmacist should assist the facility in establishing a system of record of receipt and disposition of all controlled substances to produce an accurate reconciliation and account for the use of the controlled substances on a periodic basis. 2. Resident 26 was admitted to the facility with diagnoses including chronic pain syndrome. The 6/27/11 MDS indicated Resident 26 understood others, was understood, had constant pain which made it hard to sleep at night and limited day-to-day activities. Record review was conducted on 8/15/11 at 4:10 p.m. The 8/10/11 physician's order at 4:53 p.m. indicated Resident 26's Percocet (a narcotic pain medication containing oxycodone) order was changed from 5/325 mg (a unit of measure) to 10/325 mg every three hours as needed. The Controlled Drug Record (CDR) binder found on the medication cart indicated one 10/325 mg Percocet was given to Resident 26 on 8/12/11 at 7:30 a.m., and another at 11:30 a.m. There was no evidence in the clinical record including the nurse's notes and the back of the MAR nursing gave the resident the Percocet as documented on the CDR on 8/12/11 at 7:30 a.m. and 11:30 a.m. During an observation, interview and record review of Resident 26's 8/11 MAR on 8/16/11 at 8:35 a.m., the resident's Percocet 5/325 mg dosing was reviewed in further detail. The "bubble blister" pack and the CDR for the prior Percocet tablets 5/325 mg. were not in the medication cart and were obtained for review on 8/16/11 at 8:35	F 431		

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F 431	Continued From page 62 a.m. by the director of nurse's (DON) from her narcotic disposition storage area. The CDR beginning 8/7/11 at 11:30 a.m. through 8/11/11 labeled as Percocet 5/325 mg was wrapped around a "bubble blister" pack. The CDR indicated the last Percocet 5/325 mg nursing gave was on 8/11/11 at 4:00 p.m. The balance left on the CDR indicated 15 tablets should have been left in the "bubble blister" pack. The "bubble blister" pack was also labeled Percocet 5/325 mg.; there were only fourteen tablets left (one inside each "bubble"). The physical inventory did not coincide with the CDR. During the 8/16/11 interview at 8:35 a.m., the director of nurses (DON) stated the "bubble blister" pack containing the Percocet had been in her office because the Percocet in the "bubble blister" was going to be destroyed by her and the pharmacist since the resident was no longer taking the Percocet 5/325 mg. The DON stated the back of the 8/11 MAR on top of the medication cart indicated nursing administered two Percocet 5/325 tablets on 8/11/11 at 4:00 p.m. instead of one tablet as recorded on the CDR. The DON stated nursing missed the 8/11/11 entry at 4:00 p.m. when they gave the second Percocet 5/325 mg and that was why the physical count did not match the CDR. The DON stated other information on the MAR reviewed above did not match the controlled drug record and had missing information.	F 431		

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	055884	A. BUILDING _____ B. WING _____	08/22/2011

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F 431	Continued From page 63 According to the facility's 2007 "Medication Administration Controlled Substances" policy and procedure when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record (CDR) when removing dose from controlled storage: date and time of administration and signature of the nurse administering the dose. After administering the controlled medication the licensed nurse is to document "dose administration on the MAR." According to the 2011 U.S. Department of Justice, Drug Enforcement Administration Drugs of Abuse (at www.DEA.GOV <http://www.DEA.GOV>) Norco (hydrocodone) and Percocet (oxycodone) are schedule II drugs. Schedule II drugs have a high potential of psychological or physical dependence. The controlled Substance Act requires that complete and "accurate records be kept of all quantities of controlled substances ....Each substance must be inventoried ....From these records it is possible to trace the flow of any drug from the time it is first imported or manufactured, through the distribution level ....and then to the actual patient who received the drug. The mere existence of this requirement is sufficient to discourage many forms of diversion. It actually serves ...as an internal check to uncover diversion, such as pilferage by employees."	F 431		
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	F 441	F 441 INFECTION CONTROL • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	09/30/11

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F 441	Continued From page 64 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent the spread of	F 441	1. The Director of Staff Development conducted 1:1 in serviced to Licensed Nurse C regarding maintaining infection control during treatment on 08/23/2011. Resident's 13 right buttock open area was resolved on 08/23/2011. 2. The bottle of body wash, facial scrub and powdered make up, toothbrush and toothpaste were identified and owned by Resident 15 and placed in her right stand. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Housekeeper supervisor and Director of Staff Development conducted a room checked beginning 08/16/2011 to ensure that personal belongings/ toiletries are placed in emesis basin on each resident's bedside. 2. The Director of Staff Development conducted in serviced to licensed nursing staff regarding protocol during treatment and infection control by 09/30/2011. • What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur:	

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F 441	Continued From page 65 infection when several personal care items were found unlabeled in a shared bathroom and a licensed nurse picked a roll of tape off the floor and continued to use it for one of 24 sampled residents (13) dressing change. Findings: 1. Resident 13 was admitted to the facility with diagnoses including chronic pain. A physician's order dated 8/5/11 indicated Resident 13 was to have a dressing change to her right buttock every shift that included cleaning the wound with normal saline (salt water), apply wound gel and cover with a dry dressing. During an observation of Resident 13's dressing change on 8/15/11 at 2:30 p.m., licensed nurse C (LN C) dropped a roll of tape on the floor, picked it up with her gloved hand and continued to use it to tape the clean dressing. During an interview on 8/16/11 at 7:55 a.m. with LN C she stated, "I should have replaced it with a new roll of tape because it is already contaminated." Record review on 8/19/11 at 10:35 a.m. of the facility's undated policy and procedure, "Dressings" indicated it was the policy of the facility all dressings be handled in a safe and sanitary manner. 2. During the initial tour on 8/15/11 at 8:10 a.m. with licensed nurse I (LN I), a bottle of body wash, facial scrub and powdered make-up were observed on the window sill in a shared	F 441	The Director of Staff Development or designee will observe a procedure for wound treatment daily to ensure that licensed nurses are compliant in providing a safe and sanitary environment to help prevent transmission of disease and infection. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Nursing or designee will monitor treatment licensed nurse during wound care/ treatment every Tuesdays. Consistent non compliance by staff will be reviewed with the Administrator. For Quality Assurance to audit. Issues of non compliance will be discuss to the Quality Assurance Committee on quarterly basis to trend, track and further resolve issues of non compliance. • Dates when corrective action will be completed: 09/30/2011	

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F 441	Continued From page 66 bathroom. There was also a toothbrush and toothpaste in a cup on the window sill. The items on the shared bathroom window sill were not labeled. During an interview with LN I on the same date and time, she stated she did not know who the items belonged to. She stated she had to ask the residents in the room and some of the items belonged to one resident and some items belonged to the other resident. She also stated the items should be marked with the residents name or room number.	F 441		
F 456 SS=D	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, interview and record review, the facility failed to maintain a dishroom sink when it was leaking around the rim. The drain was also leaking at the bottom of the sink and the caulking around the sink was unclean. Resident 28's bathroom sink water was cold. It is important for residents to have warm water with which to wash their face and hands because warm water not only cleans better than cold water but also feels better. In addition, most homes in this country have hot water and nursing homes are the residents' homes. Findings: 1. During the posting observation on 8/16/11 at 8:00 a.m., Resident 28 approached the surveyor	F 456	F456 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Maintenance supervisor set the boiler at 120F on 08/16/2011 to deliver tap water at 105-120F on residents sink and shower room. 2. A contractor was contacted to repair leaking rim in kitchen sink and welded on 08/17/2011. No further water leaks noted. • How the facility will identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken:	09/30/11

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F 456	Continued From page 67 and stated the water dispensed from her sink was cold and she had told the facility about it. The surveyor went into the resident's room and turned on the hot water tap to allow the water to flow for about 5 minutes. The water felt lukewarm to the touch. During an unsolicited interview on 8/16/11 at 8:30 a.m., the administrator approached the surveyor and stated the facility was aware of the resident's complaint and they had taken care of it. During an environmental tour on 8/16/11 at 9:40 a.m., maintenance staff (MS) took the water temperature dispensed from the hot water tap in the resident's sink and stated it was 99 degrees Fahrenheit. During an observation and interview on the same day, the thermometer on the boiler supplying Resident 28 with "hot" water was set at 80 degrees Fahrenheit. MS stated the thermometer should have been set higher. According to the untitled and undated policy and procedure regarding hot water temperature "boilers will be set at 110-120 degrees Fahrenheit to deliver water to residents' room and shower within the range of 105-120 degrees Fahrenheit." 2. During the initial tour of the kitchen on 8/15/11 at 7:40 a.m. the floor was wet in the dishwash area, creating a potential situation when a person could accidentally slip in the kitchen. During an interview on 8/15/11 at 7:40 a.m., dietary aide 2 (DA 2) stated the sink rim was leaking and the drain at the bottom of the sink	F 456	1. The Maintenance supervisor installed a circulator to the water heater supplying unit 3 to ensure water temperature is within acceptable range of 105-120F. 2. The Dietary staff shall be in serviced by Registered Dietitian regarding keeping the floor dry by mopping at least 2x per day to prevent hazard. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Department Heads shall continue to have daily rounds and interview resident of the water temperature daily. Findings will brought out on daily stand up meeting for immediate resolution. 2. The Maintenance staff will check water temperature every week and log results to ensure water temperature is within 105-120F • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Administrator or designee will randomly check water temperature five (5) times a week to ensure compliance. For Quality Assurance to audit.	

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F 456	Continued From page 68 was leaking as well. The maintenance supervisor (MS) was already notified. During an interview with MS on 8/16/11 at 10 a.m. he stated he would fix it. During an observation in the kitchen on 8/17/11 at 11:30 a.m. caulking was around the leaking rim of the sink and was not cleanable, a potential to harbor bacterial growth in the dishwashing sink. During an interview with MS on 8/17/11 at 11:30 a.m. he stated he should change it.	F 456	The Registered Dietitian will do random inspection on kitchen sink to ensure functioning and free from water leaks. Issues of non compliance will be brought to the attention of Quality Assurance Committee on quarterly basis for further recommendation and resolution. • Dates when corrective action will be completed: 09/30/2011	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one multiple resident bedroom (119) measured at least 80 square feet per resident. During an interview on 8/22/11 at 8 a.m. with the director of nurses (DON) she confirmed there was one room in the facility with less than the required 80 square feet of space per resident. During an observation on 8/22/11 at 9:45 a.m., Room 119, a two-person room, was measured to be 156 square feet. Each resident was provided with 78 square feet of space. The residents were not in the room at the time.	F 458	F458 BEDROOM MEASURE Facility will continue to ensure that rooms have sufficient space for staff to care for the residents. Director of Staff Development/ designee conducted in service attended by nursing and housekeeping staff to ensure that rooms are clear of clutter, safe and orderly. Department Heads will continue to perform daily rounds to ensure residents are safe including cleanliness and orderliness of the rooms. For Quality Assurance to audit. Administrator/ Designee will perform daily rounds to ensure that resident's rooms are not crowded.	09/30/11

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F 458	Continued From page 69 During an interview on 8/22/11 at 9:45 a.m., certified nurse assistant J (CNA J) stated there was sufficient room for the provision of nursing services and did not compromise the care the residents in Room 119 received due to the size of the room. Recommend waiver remain in effect.	F 458	Issues of non compliance will be brought to the attention of the staff assigned to the resident's rooms that are full of clutter. Quality Assurance Committee will meet quarterly to trend, track and further resolve issues of non compliance.	
F 461 SS=B	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety.	F 461	F461 BEDROOM-WINDOW/ FLOOR • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Maintenance staff placed a separator in room 200-208 closet to maintain privacy beginning 09/01/2011. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The Housekeeping supervisor conducted a checked on residents closet to ensure there is a separator that prevent clothing mixed up or cloth touching each other. This begun on 09/07/2011 and ongoing. The Maintenance staff placed separator on resident's closet without dividers beginning 09/12/2011.	09/30/11

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F 461	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure private closet spaces were provided for residents sharing rooms. Individual storage closet spaces are accessible only to the resident and affords the resident with privacy. Findings: 1. During the environmental tour on 8/16/11 at 9:00 a.m., closet spaces in nine resident rooms housing multiple residents had one clothing rod in each closet. Only a small round tag placed on the rod was noted between clothing laden wire hangers. During an observation and interview at the same time and place, the maintenance manager (MM) stated the small round tag on the rod divided the rod into two separate sections therefore providing the residents in the room with separate or individual closet spaces. 2. During the initial tour on 8/15/11 at 8:10 a.m. with licensed nurse I (LN I) rooms 200 to 208 had shared closets in each room. Each closet had a rod used to hang clothes. There were room numbers written with black pen on the clothing rods. Each resident's clothes were observed touching each other. There was no separation of clothing space observed in these rooms. During an interview with Resident 6 on 8/16/11 at 7:10 a.m., she stated her clothing was always	F 461	• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Laundry staff will monitor closets during the daily putting back of resident's washed clothes to ensure separators is in placed. The Certified Nursing Assistant shall report to the Charge Nurse any missing separator noted during ADL care. • How the facility plans to monitor it performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan or correction is integrated into the quality assurance system: The Social Service and Housekeeping supervisor will check at least two (2) residents closet a day to observe that clothes separator is in place and not touching any other clothes. For Quality Assurance to audit. Issues of non compliance will be brought to the attention of Quality Assurance committee during quarterly meeting for further review and resolutions.	

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F 461	Continued From page 71 touching her roommates and she sometimes got the clothing mixed up.	F 461	Dates when corrective action will be completed: 09/30/2011	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each 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 failed to maintain and/or accurately document records for six of 24 sampled residents (7, 13, 18, 22, 24, and 27). Residents 7, 13, and 22 had medication administration records (MARs) lacking signatures and corresponding initials identifying licensed nurses who administered medications. Resident 13 had a weekly summary that did not include updated wound treatment previously ordered. For Resident 18, the facility failed to obtain an order from the physiciain to discharge the resident from the facility. Resident 24 had incomplete documentation at discharge. There was no documentation on the back of Resident 27's MAR regarding an Ativan given to the resident. Findings:	F 514	F 514 RESIDENTS RECORDS, COMPLETE/ ACCURATE Facility will continue to maintain complete and accurate clerical records in accordance with accepted professional standards. • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The Resident's right buttocks wound was healed on 08/23/2011. The Director of Nursing conducted 1:1 in service to Licensed Nurse on 09/07/2011 that did the weekly summary on 08/12/2011 regarding accuracy of documentation to include all current treatment and resident condition every weekly progress notes. 2. The Licensed Nurse involved for Resident's 13 each of signature for Seroquel were in serviced on 08/23/2011 by the Director of Nursing regarding the importance of signing medication communication record consistently. 3. The Licensed Nurse G made a late entry on the initial for Resident's 22 Oscal. Medication was given as ordered on timely manner.	09/30/11

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F 514	Continued From page 72 1. Resident 13 was admitted to the facility with diagnoses including chronic pain. A physician's order dated 8/5/11 indicated cleanse Resident 13's right buttock abrasion with normal saline (a salt solution), apply wound gel and cover with a dry dressing every shift. A review on 8/17/11 at 8:10 a.m. of a "Licensed Nurse Weekly Summary" dated 8/12/11 "Treatment Required" indicated, "Apply antiseptic on R/L (right and left) buttock as prophylactic." It did not identify the current treatment to the right buttock wound. During an interview on 8/17/11 at 7:50 a.m. licensed nurse B (LN B) stated the weekly summary ending 8/12/11 should have listed the open wound. LN B confirmed the wound was found on 8/5/11 at 2 p.m. 2. Resident 13's MAR was reviewed on 8/15/11 at 3:40 p.m. The MAR for August identifying the medication "Seroquel" lacked signatures and initials identifying the licensed nurses who administered the medication. 3. Resident 22's MAR was reviewed on 8/18/11 at 9:25 a.m. The MAR for August identifying the medication "Oscal" lacked signatures and initials identifying the licensed nurses who administered the medication. During an interview on 8/18/11 at 9:30 a.m. licensed nurse G (LN G) stated after administering medication to the resident we are "supposed to sign with signature. We forgot to	F 514	4. The Resident's 24 personal belongings were picked up on 08/18/2011 by responsible party. The Social Services designee contacted the responsible party on 08/23/2011 to send a fax letter of confirmation of receipt for Resident's 24 personal belongings. Fax acknowledgement was received on 08/23/2011 and filed in resident's health record. 5. The Director of Nursing conducted 1:1 interviewed to Licensed Nurse that pulled out Ativan for Resident's 18 on 08/18/2011 regarding facility's policy and procedure on administration of medication. 6. Resident 18 is no longer in the facility. The Licensed Nurse involved was in serviced on 08/23/2011 the Director of Nursing regarding the importance of obtaining an updated discharged order on consistent basis. 7. Licensed Nurse M made a late entry on the administration of Lopid, the medication for Resident 7 was given as ordered. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Medical records conducted an audit to resident's with treatment to ensure this are addressed in Nurses weekly progress notes beginning 08/24/2011 and ongoing.	

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SAN TOMAS CONVALESCENT HOSPITAL	3580 PAYNE AVENUE SAN JOSE, CA 95117

(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 514	Continued From page 73 sign on the signature line." 4. Resident 24 was admitted to the facility with diagnoses of diabetes mellitus (increased sugar in the blood). Review of Resident 24's chart on 8/18/11 at 3:20 p.m. indicated the "Inventory of Personal Items" was not signed or dated by the resident or responsible party on admission or discharge. During an interview on 8/18/11 at 3:30 p.m. the social services director (SSD) confirmed Resident 24's " Inventory of Personal Items was not signed." Review of policy and procedure "Valuables List" (undated on) 8/18/11 at 3:45 p.m. indicated "An inventory of all resident's personal effects and valuables made upon admission and discharge. The inventory list shall be . . . signed by the resident or his representative and a hospital witness with one copy being retained by each." 5. Resident 27 was admitted to the facility with diagnoses including peripheral neuropathy (pain in the arms and legs). During record review on 8/15/11 at 1:00 p.m., the 12/3/11 physician's order indicated nursing was to give Resident 27 one 0.5 mg Lorazepam (an anti-anxiety medication) tablet every eight hours as needed. The CDR record indicated one 0.5 mg Lorazepam tablet was removed on 8/8/11 at 1:30 p.m. There was no evidence on the back of the 8/11 MAR nursing gave the resident the	F 514	2. The Director of Nursing conducted in service to licensed nursing staff on 08/21/2011 regarding the importance of facility's policy and procedure with medication administration and another in service by DON on 08/29/2011 regarding the necessity of updating discharge order and completing resident's personal inventory list upon discharge. 3. The Pharmacy Nurse consultant conducted a 3 way audit on all medication administration record and medications beginning 09/07/2011, 09/089/2011 and 09/09/2011 to ensure medications are given as ordered and signed as given. 4. The Director of Nursing reviewed all residents discharge for the months of July, August and ongoing to ensure that resident inventory sheets are signed by resident/ responsible party and discharge order is current and in placed. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Medical Records will continue to make daily audit to ensure that medications are signed off and they are given by the Licensed Nurse. A weekly audit report shall be given to the Director of Nursing.	

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F 514	Continued From page 74 Lorazepam. During an interview and record review on 8/15/11 at 2:00 p.m. with licensed nurse Y (LN Y), LN Y stated the 8/11 MAR did not indicate nursing gave the resident the Lorazepam and there was no evidence if the resident obtained relief from anxiety. 6. Resident 18 was admitted to the facility with diagnoses including acute respiratory failure. The Admission Assessment indicated Resident 18 was independent in cognitive skills for daily decision making and was receiving physical therapy (PT) and occupational therapy (OT). The clinical record was reviewed on 8/19/11. The physician's order dated 6/2/11 indicated a plan to discharge patient home on 6/5/11 with home PT/OT/RN (registered nurse). The physician's order dated 6/3/11 indicated patient needs to have blood culture and sensitivity times two done on 6/7/11 (one week after completion of antibiotics) by home health RN. During an interview and record review with the DON on 8/19/11 at 8:55 a.m., she stated the nurse's notes dated 6/5/11 indicated the nurse in charge had "communicated" with the medical doctor, but there was no documented order for discharge on 6/6/11. 7. During record review on 8/17/11 of the physician's order dated 7/3/11 indicated Resident 7 was to receive Gemfibrozel (lopid) 600 milligram one tablet by mouth daily before breakfast for hyperlipidemia there was no documentation in the medication administration record (MAR) Resident 7 received the 6 a.m.	F 514	2. All Discharge health record shall go to the nursing office for review prior to Medical Records final audit and closure. 3. The Pharmacy Nurse consultant will do a quarterly three (3) way audit. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and thee corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: 1. The Director of Nursing or designee will review at least 5 clinical records each month and issues of non compliance will be addressed to the specific licensed nurse. 2. The Director of Nursing or designee will randomly review at least 5 medication administration records daily and observe medication administration pass to ensure compliance. 3. Quality Assurance Committee will meet quarterly to trend, track and further resolve issues on non compliance. • Date when corrective action will be completed: 09/30/2011	

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F 514	Continued From page 75 dose on 8/17/2011. During an interview with licensed nurse G (LN G) on 8/17/11 at 2 pm. LN G stated the medication should have been given at 6 a.m. During an interview on 8/18/11 at 3:00 p.m. with licensed nurse G she stated licensed nurse M did not document the medication she gave.	F 514		
F 517 SS=F	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure emergency food supply was sufficient to serve 130 residents and 98 staff in the event of a disaster. This failure has the potential to result in starvation of residents and staff in the facility during a disaster. Findings: During an observation, interview and record review of the emergency food supply with the registered dietician (RD) on 8/16/11 at 8:50 a.m., she stated the facility had food for 130 residents and 30 staff members a total of 160 people for 3 days. However, the following servings were noted in storage. 1. For day one: corned beef hash = 10 cans = 13 servings/can x 10 cans = 130 servings, needed	F 517	F 517 WRITTEN PLANS TO MEET EMERGENCIES/ DISASTER • How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The emergency food supply will be re-stocked based on 230 persons per day to include 130 residents and 98 employees total for the following entrée items on the 3-day emergency food supply; the beef stew, corned beef hash, and chili beans will be re-stocked at 18 (#10) cans. 2. The emergency food supply will be maintained at 20 (#10) cans par stock level at all times. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents found affected in this deficient practice. The Registered Dietitian conducted 1:1 in service to	09/30/11

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F 517	Continued From page 76 was 160. 2. For day three: beef stew = 5 cans x 13 servings = 65 servings 3. For day four: chili beans = 12 cans x 13 servings = 156 servings During an interview on 8/16/11 at 8:50 a.m., the RD stated the assistant dietary supervisor (ADS) did the inventory of emergency food. There was not enough emergency food supply available. The written emergency food plan supply was not maintaned and monitored. During an interview on 8/16/11 at 9:00 a.m., the ADS stated some supply was at the back of shelves he should organize the emergency food supply storage and lists the emergency food supply needed. During record review on 8/17/11, the undated emergency plan for the facility indicated the total number of residents was 130 and the total number of staff in a 24 hour period was 98 a total of 228 people for one day, not 160 people per day. The facility's policy no. 870 dated 2009, "Food and Supplies for Emergencies" indicated the facility maintain at least a seven day supply of staple foods and at least two days supply of perishable foods in the regular storeroom inventory.	F 517	Assistant Dietary Supervisor regarding stocking 7 day supply of emergency food. • What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Assistant Dietary Supervisor will maintain a running inventory log every month to monitor par stock level. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction integrated into the quality assurance system: The Registered Dietitian will monitor thru inventory check weekly to ensure that there is adequate supply of food for 230 people for 7 days. Quality Assurance committee will meet quarterly to trend, track and further resolve issues of non compliance. Dates when corrective actions will be completed: 09/30/2011	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	F 518	F 518 TRAIN ALL STAFF-EMERGENCY PROCEDURES/ DRILLS	09/30/11

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F 518	Continued From page 77 The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff on each shift were in-serviced on diaster procedures two times a year. Staff may not be able to respond appropriately to a disaster if they do not know the correct diaster procedures. Findings: During an interview and review of the "Disaster Drill Report" with the director of staff development (DSD) on 8/17/11 at 3:35 p.m., she stated the disaster drills were performed by an outside resource company and were done on 11/17/2010 for the day shift staff and the disaster problem presented was for a gas line explosion. The second disaster drill was performed on 6/27 and 6/28/2011 for the evening and night shift staff and the disaster problem presented was an earthquake. She stated she did not know if all three shifts should have the same diaster problem presented or if all three shifts should be done twice a year. During an interview with the outside resource company staff member on 8/18/11 at 2:30 p.m., he stated there was no way all three shifts could attend the disaster drills around the same time. He stated he tried to present the same disaster problem at both disaster drills, but did not do it this time.	F 518	• How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Director of Staff Development conducted a disaster drill on all shifts beginning 09/15/2011 and ongoing to ensure all shifts attended disaster drill and will repeat every six months on all shifts. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: There are no residents affected. • What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Director of Staff Development shall review, records and post disaster drill within 72 hours to ensure that all shifts attended disaster drill.	

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F 518	Continued From page 78 The facility's undated policy and procedure, "Fire and Disaster Plans", indicated drills are conducted to familiarize all personnel with our emergency procedures and to establish them as a matter or routine. Disaster drills are conducted on each shift twice a year.	F 518	• How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system: The Director of Staff Development shall monitor the attendance/ shift for disaster drill. A report shall be provided to the attention of administrator for correction action. The Director of Staff Development will provide a quarterly report to the Quality Assurance Committee for review and recommendations. • Dates when corrective action will be completed: 09/30/2011	