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

PRINTED: 02/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555554	A. BUILDING _____ B. WING _____	01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANISH CARE CENTER	10805 EL CAMINO REAL ATASCADERO, CA 93422

(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 - Licensing and Certification, during an Annual Recertification Survey. Representing the Department: 32970, HFEN 33720, HFEN 34313, HFEN (Trainee) 34561, HFEN (Trainee) Facility census was 63. Resident sample size was 15.	F 000		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure overhead light cords were accessible for use for one sampled resident (Resident 3) and four unsampled residents (Residents 18, 19, 20, and 21). This failure created potential inability to meet residents' needs for activities that requires adequate lighting necessary for comfort and safety. Findings: During initial tour on 1/20/15, at 11:15 a.m.,	F 256	This plan of correction shall constitute this facility's written credible allegation of compliance for the deficiencies noted. **F256 483015(h)(5) Adequate & comfortable lighting levels** The facility must provide adequate and comfortable lighting levels in all areas. A. For the residents 3, 18, 19, 20, and 21 affected by the deficient practice, the residents' light cords were checked by maintenance department and replaced immediately on 1/20/15 to ensure length was appropriate and within each residents reach. B. Maintenance department inspected the facility over bed light cords for all residents potentially affected on 1/20/15. All over bed light cords were inspected immediately to ensure length of cord was within residents reach and did not identify any additional light cords that were out of resident reach. C. The DSD or designee will in-service starting on 2/10/15 regarding reporting over bed light cord lengths to the maintenance department if found that a resident is unable to reach.	

Revised POC Accepted 2/23/15 MFE

Rev. 2/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 2/2/15

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 256	Continued From page 1 accompanied by the director of nursing (DON), Resident 3's bed on Room 25A, was observed to be parallel to the wall and 2 feet away from the wall. Resident 3's overhead light was facing the foot of the bed with the cord hanging down approximately 2 feet from the foot of the bed. During a concurrent interview with the DON, the DON acknowledged that Resident 3 would not be able to reach his overhead lighting with the bed in this position. During the initial tour of the facility, on 01/20/15, at 11 a.m., with the director of staff development (DSD), observation revealed, the overhead light cords for Resident 18 in room 9A, Resident 19 in room 9B, Resident 20 in room 11, and Resident 21 in room 12B, were approximately five feet away making them unreachable for residents to turn their overhead lights on and off. During a concurrent interview, the DSD agreed, the cords for overhead lights were too short and should be longer for residents to reach and control the lighting.	F 256	D. The Director of Maintenance will conduct routine facility rounds at least weekly to ensure compliance of reporting any unreachable over bed light cords for immediate extension in length. Any discrepancies will be discussed at the monthly quality assurance committee meeting for recommendations of re in-servicing. E. Corrective action will be completed by 2/25/15.	
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 meet professional standards of quality when: 1. a stool softener was not held during episodes of loose bowel movement, a tab alarm was not	F 281	**F281 483.20(k)(3)(i) Service provided meet professional standards** The services provided or arranged by the facility must meet professional standards of quality. 1A. Resident 3 was assessed by DON on 1/23/15 and identified no negative outcomes noted from administering stool softener, tab alarm was removed as order was discontinued, and sheepskin covers to wheelchair was provided immediately.	

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F 281	Continued From page 2 discontinued, and a sheepskin to cover wheelchair arms were not provided, as ordered by the physician for one sampled resident (Resident 3). 2 a. Resident 17's order for Tylenol was not transcribed to the medication administration record (MAR) correctly and was not discontinued as ordered, and b. the order for glucagon (a hormone that raises the concentration of sugar in the bloodstream), to be administered as needed for low blood sugar, was not clarified with the physician when it did not contain a parameter (numerical value) to define low blood sugar. This failure put both residents at risk for harm and discomfort. Findings: According to Fundamentals of Nursing by Potter and Perry, copyright 2013, Chapter 23, page 305, Legal Implications in Nursing Practice: Health Care Providers Orders, states in part, "..The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders: if you find one to be erroneous or harmful, further clarification from the provider is necessary..The nurse is responsible in transcribing written orders correctly.." 1. During a concurrent observation and interview on 1/21/15, at 9:20 a.m., Resident 3 was sitting in	F 281	1B. Medical records audited orders on 1/23/15 for stool softeners, tabs and sheep skin padding to wheelchair and no other residents were identified. For all residents potentially affected by this deficient practice, audits will be conducted by DON and or designee to ensure stool softeners are administered as ordered by the physician DSD or designee to ensure CNA worksheets are filled at the beginning of every shift for resident interventions as ordered by physician and are on resident as ordered, such as tabs and sheepskin padding. 1C. The DON and or designee will in-service all licensed nursing starting on 2/10/15 on administration of stool softeners as ordered by the physician. DSD or designee to in-service CNAs starting on 2/10/15, to fill out their CNA worksheets at the beginning of every shift for resident interventions as ordered by physician, such as tabs and sheepskin padding, and ensure items ordered are in place. 1D. The DON and or designee will conduct routine weekly audits for the next month, followed by a monthly audit for two additional months for administration of stool softeners as ordered by the physician. DSD or designee will conduct weekly audits to check interventions ordered by physician are in place such as tabs and sheepskin padding. Any discrepancies will be discussed at the	

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F 281	Continued From page 3 his wheelchair, inside his room, fully dressed with tab alarm (alerting device when the resident gets out of a sitting position) attached to his shirt. Resident 3's wheelchair arms were observed not to have any padding in place. When certified nursing assistant (CNA 1) was asked if the alarm was ordered for Resident 3, CNA 1 stated, "Yes." When surveyor indicated that there was an order to discontinue the tab alarm on 1/15/15, CNA 1 stated, "I didn't know that." When CNA 1 was asked about padding to be in place for the wheelchair arms, CNA 1 stated," I really don't know about that." On 1/21/15 at 8:30 a.m., a review of Resident 3's "Physician Order Report" for January 2015, revealed, the order "Tabs in bed and wheelchair, to alert staff if resident getting up unassisted" was discontinued on 1/15/15. Review of same record revealed, an order of "sheepskin covers to wheelchair arms", dated 6/30/14 On 1/23/15, at 10 a.m., during a concurrent review of the "Physician Order Report" for January 2015, and interview with the director of nursing (DON), revealed, Resident 3 had an order dated 8/31/14, for colace (a stool softener)100 mgs every 12 hours (at 8 a.m. and 8 p.m.), with ""special instructions" for licensed nurses to hold the medication if Resident 3 has loose stool. Review of Resident 3's "Bowel Elimination" flowsheet revealed, on 12/4/14, Resident 3 had loose bowel movements during the day, evening, and night shifts. However, review of the medication administration record (MAR), revealed, Resident 3 received the colace on both the 8 a.m. and 8 p.m. doses on 12/4/14. The medication was not held due to loose stool, as ordered by the physician. During an interview,	F 281	monthly quality assurance committee meeting for recommendations of re in-servicing. 1E. Corrective action will be completed by 2/25/15. 2aA. Resident 17 was assessed by DON and there were no negative outcome for the medication ordered and resident did not receive the medication past stop date of 1/5/15. Medication was discontinued. 2aB. For all residents with an order of Tylenol potentially affected by this deficient practice, Medical records audited all Tylenol orders to ensure transcription of medications with stop dates are reflected in MARs on 1/23/15 and no other residents were identified. 2aC. The DON and or designee will in service all licensed nursing starting on 2/10/15 on transcription of medication to MAR. 2aD. The DON and or designee will conduct routine monthly audits for the next three month for transcriptions of medication. Any discrepancies will be discussed in the monthly quality assurance committee for recommendations of rein-servicing or changes to the current policy and procedure. 2aE. Corrective action will be completed by 2/25/15.	

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F 281	Continued From page 4 the DON acknowledged, the medication was given contrary to the physician orders. 2. a. Review of Resident 17's physician's order, dated 1/3/15, revealed an order for "Tylenol 325 mg (milligrams) 2 TAB (tablet) PO (by mouth) q4 (every four hours) PRN (as needed) for fever > (greater than) 100 degrees x (for) 3 days". Review of Resident 17's MAR, for January 2015, revealed an order transcription dated 1/3/15, for "Tylenol 325mg, 2 tab po q 4 hrs PRN Fever > 100 degrees." The transcription was lacking the physician's order to take this medication for 3 days only. In addition, the order was never discontinued after the original order for three days had expired. b. Review of Resident 17's physicians order, dated 9/3/14, revealed, "Glucagon 1 mg PRN inject IM (in the muscle), as needed for hypoglycemia (low blood sugar)". There were no written parameters that will define the "low the blood sugar" necessary to guide the licensed nurses when to administer the medication. Review of Resident 17's MAR for January 2015, revealed an order transcription dated 9/3/14, "Glucagon 1 mg IM As Needed HYPOGLYCEMIA". There were no written parameters defining the "low the blood sugar" necessary to guide the licensed nurses when to administer the medication. During an interview with licensed nurse (LN 3), on 1/21/15, at 1:50 p.m., LN 3 agreed the order for Tylenol should have been transcribed on the MAR for three days only, and discontinued after the three days had expired. LN 3 agreed, the	F 281	2bA. Resident 17 was assessed by licensed nurse, the physicians' orders were immediately consulted upon with their Physician, and the Glucagon was discontinued on 1/22/15. 2bB. DON reviewed all residents with glucagon orders on 1/23/15 and no other residents were affected. For all residents potentially affected by this deficient practice all glucagon orders are reviewed on a monthly basis or as needed. 2bC. The DON and or designee will audit physician order recaps on a monthly basis or as needed. 2bD. The DON and or designee will audit the physician order recaps and discuss any discrepancies at the monthly quality assurance committee meeting for recommendations of re in-servicing or changes to the current policy and procedure. 2bE. Corrective action will be completed by 2/25/15.	

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F 281	Continued From page 5 physicians order for Glucagon should have been clarified with the physician as to the parameters for "hypoglycemia."	F 281		
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, interview, and policy review, the facility failed to ensure that food was stored under sanitary conditions. This failure had the potential to cause foodborne illness for all residents receiving prepared meals in the facility. Findings: During a tour of the facility's kitchen on 1/20/15 at 11:45 a.m., the following were observed: In refrigerator #1, a frozen pink dessert tray and a plastic container with leftover mixed vegetables had no date or label. Also observed, was a plastic container with leftover cooked green bean that was dated 1/14/15, kept for 6 days after it was opened.	F 371	**F371 483.35(i) Food procure, store/prepare/serve-sanitary** The facility must- Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and Store, prepare, distribute and serve food under sanitary conditions A. No resident was identified. All unlabeled items as well as items stored beyond 72 hours were immediately thrown out on 1/20/15. B. For all residents potentially affected by this deficient practice, licensed nurses accessed residents and no one presented with GI symptoms on 1/20/15. C. The Dietary manager or designee will in-service all dietary staff in regards to policy and procedure on proper storage and labelling. 2/9/15 D. The Dietary manager or designee will conduct daily checks of storage areas in order to ensure compliance with food storage regulation and discuss any discrepancies at the quality monthly assurance committee meeting for recommendations of re in-servicing. E. Corrective action will be completed by 2/9/15.	

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F 371	Continued From page 6 In refrigerator #2, a plastic bag of strawberries and pepperoni had no date and label. In freezer #2, a box of frozen bacon and fries were open and uncovered with no date and label. One box of of frozen turkey dogs and sausage were observed to be uncovered. In the dry storage section, one bag of hot dog buns, three loaves of bread, four cans of diced pimentos, one box of powered mashed potatoes, had no delivery or expiration dates and labels. During an interview with the director of dietary services (DDS) on 1/19/15 at 12:30 p.m., she acknowledged, several food items did not contain proper labeling and date. Review of the facility's policy on "Food Policy and Sanitation", dated 2013, states in part, "..4. Food Storage..All time and temperature control for safety (TCS) leftovers are labeled, covered, and dated when stored. They are used within 72 hours (or discarded).. Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer's guidelines.."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	**F441 483.65 Infection control, prevent spread, linens** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility must establish an Infection Control Program under which it- (a) Infection Control Program (1) Investigated, control, 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.	

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F 441	Continued From page 7 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 ensure a safe and sanitary environment when contact precaution (everyone coming into a resident's room is asked to wear a gown and gloves to prevent spread of infection through touching of infected surface) order were not followed for one unsampled	F 441	(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 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 A. For resident 16 an infection control sign was immediately placed outside their door on 1/20/15. B. All residents place on contact precautions have the possibility of being affected and the DON or designee checked all residents on contact precautions on 1/20/15 and no other resident was affected and all signs were posted by the door. C. The ADON or designee will starting on 2/10/15 in service all nursing staff in regards to infection control policies and procedures specifically to posting signage.	

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F 441	Continued From page 8 resident (Resident 16). This failure placed the residents, staff, and visitors at risk for the spread of disease and infection. Findings: On 1/20/15, at 10:15 a.m., during tour with licensed nurse (LN 1) outside of room 28C, the room had no signage indicating any special precautions. LN 1 escorted surveyor to the room and introduced surveyor to Resident 16. Surveyor observed room surroundings and bathroom. When surveyor was exiting to another room (Room 26) in the same hallway, CNA 1 was observed entering Room 28 with protective gown and gloves. On 1/20/15, at 10:20 a.m., during a concurrent interview with LN 1 and CNA 1, they were asked why CNA 1 put on the gloves and gown. CNA 1 stated, "Because Resident 16 has lice." LN 1 stated, "I didn't know that." Upon returning to room 28C, it was observed that there were gloves and gowns hanging on the outside of the room door, but there was no signage posted indicating the need for personal protective equipments (PPEs). When LN 1 was asked about the need for signage, she stated, "There should be signage posted on the outside door or wall." On 1/21/15, at 12:30 p.m., record review revealed, on 1/19/15, at 3 p.m., and order was written by Resident 16's physician, "Apply OTC (over the counter) lice shampoo per manufacturer instructions, contact precautions." On 1/22/15 at 2 p.m., during an interview with the DON, she was asked what precautions would be	F 441	D. The ADON or designee will monitor monthly adherence to infection control policy and procedures. Any discrepancies will be discussed at the monthly quality assurance committee meeting for recommendations of in-servicing or changes to the current policy and procedure. E. Corrective action will be completed by 2/25/15.	

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F 441	Continued From page 9 used for lice, and she stated, "Contact precautions." When asked if this precaution include posting signage outside of the resident's rooms? DON stated, "Yes." On 1/23/15, at 10:15 a.m., review of facility "Infection Control Flow Sheet" undated, under subheading, "Transmission Based Precautions", states in part, "..Contact Precautions are in addition to Standard Precautions..Precaution set up in or near room with PPE, sign on door.."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to provide: 1. a safe environment in room 10 when the base board in the bathroom was noted to be pulling away from the wall putting residents using this bathroom at risk for injury. 2. a functional environment when two walkers, two boxes, and a floor buffer were obstructing easy access to emergency water supplies creating potential delay of accessing water supply in case of emergency or disaster. Findings:	F 465	**F465 483.70(h) Safe/ Functional/ Sanitary/ Comfortable Environ** The facility must provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. 1A. For the one resident in room 10, resident was accessed with no injury identified and the base board in the bathroom was fixed immediately by maintenance department on date 1/20/15. 1B. For all residents potentially affected by this deficient practice, all bathrooms were inspected by the maintenance department on 1/20/15 and there were no further identified issues during the facility rounds. 1C. The DSD or designee will in-service starting on 2/10/15 regarding reporting damaged equipment to the maintenance department.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555554	A. BUILDING _____ B. WING _____	01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANISH CARE CENTER	10805 EL CAMINO REAL ATASCADERO, CA 93422

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F 465	Continued From page 10 1. During an initial tour and observation of the facility, on 01/20/15, at 11 a.m., with the director of staff development (DSD), the bathroom's baseboard in room 10 was noted to be pulling away from the wall creating a safety issue for residents walking away from the commode. During a concurrent interview, the DSD agreed the protruding baseboard creates a safety issue for residents. Review of the facility's "Preventative Maintenance Program", revised 1/22/08, states in part, "..Preventative maintenance is a continuous and systematic process aimed at preventing or retarding the deterioration of a building, equipment or grounds and eliminating or minimizing equipment outages.." 2. On 1/21/15, at 2 p.m., during tour of the emergency water supply storage area, accompanied by the maintenance supervisor and the corporate maintenance supervisor, emergency water bottles (total of 222 gallons) were observed to be stacked on three shelves. In front of the shelving were 2 walkers, 2 paper boxes filled with paper and 1 buffer machine (an electrical floor scrubber that is used to clean and maintain non-carpeted floors) blocking access to the water supply. On 1/21/15, at 2 p.m., during an interview, the corporate supervisor stated, "Oh that should not be here (pointing to the walker, boxes and buffer machine)." Both the corporate maintenance supervisor and facility maintenance supervisor, acknowledged by nodding their heads, that it would be very difficult to access the water during an emergency. The corporate maintenance supervisor stated, "That all needs to be moved	F 465	1D. The DSD or designee will conduct routine weekly facility rounds to ensure compliance of reporting any damaged equipment to the Director of Maintenance or administration. Any discrepancies will be discussed at the monthly quality assurance committee meeting for recommendations of in-servicing or changes to the current policy and procedure. 1E. Corrective action will be completed by 2/25/15. 2A. No residents were affected; however items obstructing easy access to emergency water were immediately removed on 1/21/15 by Maintenance department and placement of stripping on asphalt was painted in front of water storage on 1/26/15 to signify keeping area clear. 2B. For all residents potentially affected by this deficient practice, rounds were conducted by Maintenance department on 1/21/15 and no one was affected by this deficient practice. 2C. The DSD or designee will starting on 2/10/15 in-service all staff to maintain clear access to emergency water storage and to report to the maintenance supervisor in the event of any items blocking access.	

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DANISH CARE CENTER	10805 EL CAMINO REAL ATASCADERO, CA 93422

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F 465	Continued From page 11 out (directing the facility supervisor to move the items)."	F 465	2D. The Director of Maintenance will conduct weekly rounds for the duration of one month followed by monthly inspections ensuring clear access to emergency water storage. Any discrepancies will be discussed at the quality assurance committee meeting for recommendations of in-servicing or changes to the current policy and procedure. 2E. Corrective action will be completed by 2/25/15.	