STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HLTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

(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 a federal recertification survey. Representing the Department of Public Health: HFEN, 2665/32515 HFEN, 1699/17332 HFEN, 1408/14362 HFEN, 3011/36570 RD, 2579/31472 The facility census was 125. The sample size was 24.	F 000	**F156** **Temporary and Permanent Correction** **It is the Policy of this Facility to Post all information as required by law.** **Facility Administrator immediately corrected the posting to include the correct phone number and address for the agency responsible for protection and advocacy for the rights of individuals with developmental disabilities and mental illness. Administrator also added statement "Resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility. Administrator will monitor postings monthly for one quarter to ensure that postings remain in place if good compliance, monitoring will be reduced to quarterly surveillance completed by Administrator and reported to Quality Improvement Committee.**	Accepted 5-12-16 aw 05/07/2016
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Portula	Administrator	4/16/2016

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 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the name, address, and telephone number of the protection and advocacy network (system established to protect and advocate the rights of individuals with developmental disabilities and mental illness); and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. These failures resulted in facility residents not being informed of their right to access the advocacy network for assistance and right to file a complaint with the State survey and certification agency concerning abuse, neglect, and misappropriation of resident property. Findings:	F 156		

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F 156	Continued From page 3 An inspection of the facility "physical plant" was conducted on 4/6/16. Included in the inspection was the facility's provision of Federally required informational postings. The facility had not posted the name, address, and telephone number of the protection and advocacy network or a statement that a resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. An interview was conducted with Administrative Staff (AS) 1 on 4/6/16 at 9 a.m. AS 1 stated they were not posted.	F 156		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility failed to identify skin breakdown for 1 of 24 sampled residents (6). This failure had the potential for the development of severe tissue damage.	F 314	**F 314** **Temporary and Permanent Correction** **It is the policy of this facility to ensure that residents who enter the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.**	**05/07/2016**

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F 314	Continued From page 4 Findings: Resident 6 had diagnoses including diabetes and hemiparesis (paralyzed on one side). A Minimum Data Set (MDS, an assessment tool), dated 2/18/16, indicated Resident 6 was unable to ambulate and used a wheelchair as his primary mode of locomotion. His cognition and memory was intact. An interview was conducted with Resident 6 on 4/5/16 at 7:30 a.m. He was seated in his wheelchair in his room waiting for his breakfast. Resident 6 stated he had just had a shower and his "butt is very sore." Resident 6 stated he wanted them to put the "cream on it, but they ran out of cream." Resident 6 stated his buttocks had been sore for two weeks and he had told staff about it. An interview was conducted with Licensed Nurse (LN) 1 on 4/5/16 at 7:45 a.m. LN 1 was asked if she was aware Resident 6 was complaining of a painful buttock and was requesting a cream. LN 1 stated she was not aware and she had no knowledge of Resident 6 having any problems with the skin on his buttocks. LN 1 assessed Resident 6's buttocks on 4/5/16 at 1 p.m. A circular red excoriated area approximately 6-7 centimeters extended over the Resident's right and left buttocks below the tailbone. A circular open break in the skin, approximately 1 centimeter in size was on the right buttocks. LN 1 acknowledged Resident 6's buttock was excoriated and there was a breakdown of the skin. LN 1 stated she would obtain a treatment order.	F 314	**Treatment order was immediately obtained for Resident #6. Treatment is being carried out as ordered. Certified Nursing Assistant was informed that any complaints by residents should be reported to Charge Nurse. Inservice will be provided by Staff Development Coordinator to all Certified Nursing Assistance that covers facility policy on reporting all complaints and changes in resident's condition; including any skin breakdown or redness that is observed during daily care.** **To ensure that future residents who enter the facility without pressure sores do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; Director of Nursing will monitor Certified Nursing Assistants reporting, and skin integrity reports 5 days a week for one month. If good compliance is maintained, monitoring will be reduced to monthly monitoring of skin integrity reports by the Director of Nursing.**	**05/07/2016**

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F 314	Continued From page 5 A Skin Monitoring Comprehensive Certified Nurse Assistant (CNA) Shower Review for Resident 6, dated 4/5/16, included, in part, the following: " Perform a visual assessment of the resident's skin when giving a shower. Report any abnormal looking skin to charge nurse immediately. " Documentation on the sheet revealed redness of Resident 6's groin area was noted. No other skin abnormalities were documented. An interview was conducted with CNA 1 on 4/5/16 at 1:15 p.m. CNA 1 stated she had showered Resident 6 that morning. CNA 1 said she evaluated Resident 6's skin while he was in the shower and completed a skin monitoring shower sheet. CNA 1 stated she documented on the shower sheet Resident 6 had groin redness but she did not document his red, excoriated buttocks. CNA 1 acknowledged she did not report the excoriation on the Resident's buttocks to the licensed nurse.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as was	F 323	**F 323** **Temporary and Permanent Correction** **It is the policy of this facility to ensure that the resident environment remains as free as accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** **Broom left unattended in hallway was removed. Piece of rebar that protruded was cut off. Power Strip that was dangling was removed. The 4 X 4 wooden post was replaced.**	**05/07/2016**

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F 323	Continued From page 6 possible when: 1. A broom was left unattended in a hallway 2. A piece of rebar (re-enforcement metal bar used to strengthen concrete) protruded from the floor 3. A length of a power strip electrical cord was left loosely dangling from a wall mounted television 4. A 4 x 4 wooden post with significant rot was a partial support structure for a patio eve. These failures presented a potential tripping/accident hazard for residents, staff, and visitors. Findings: 1. A general inspection of the facility environment was conducted on 4/6/16 beginning at 9:40 a.m. A broom was observed left unattended between rooms 55 and 53 on Station Two. The broom was propped against the wall and projected into the hallway. At 9:45 a.m. Housekeeping Staff (HS) 1 repositioned the broom against the wall, then walked away leaving the broom unattended. HS 1 was interviewed regarding the storage of the broom when not in use. HS 1 stated when not being used, the broom should be stored in a utility closet or on a housekeeping cart. HS 1 acknowledged the unattended broom propped against the wall was a potential tripping hazard for residents, staff and visitors. 2/3. Observation in the "Physiotherapy"/activity/ dining room adjacent to room 48 on 4/6/16 noted a piece of rebar metal approximately 1/2 inch in length protruding out of the concrete flooring. An additional observation noted an electrical cord which loosely dangled from a wall mounted television into a loop on the floor.	F 323	**To ensure that future residents, staff and visitors are protected from tripping/accident hazards, inservice will be provided by the Staff Development Coordinator on facility policy to keep environment free of accident hazards. Administrator or designee will monitor environment daily 5 days each week for one month to ensure environment is free of accident hazards. If good compliance is maintained, monitoring will be reduced to monthly environment checks by housekeeping supervisor and quarterly surveillance by Asst. Administrator. Monitoring is reported to the Quality Improvement Committee to ensure continued compliance.**	**05/07/2016**

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F 323	Continued From page 7 4. Observation on the "20's-40's" patio noted a 4 x 4 post with a significant amount of wood rot (approximately 90% rotted through). The 4 x 4 post was part of a support structure for a section of patio eve. An interview was conducted with Maintenance Staff (MS) 1 on 4/6/16 at 2:45 p.m. MS 1 acknowledged the piece of protruding rebar and dangling power cord had the potential to be a tripping/accident hazard for residents, staff, and visitors. He stated the support structure was constructed to support a previously sagging patio eve. He stated the rotted 4 x 4 needed to be replaced.	F 323		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356	**F 356** **Temporary and Permanent Correction** **It is the policy of this facility to post the nurse staffing data required on a daily basis at the beginning of each shift. Data will be posted; In a clear and readable format, In a prominent place readily accessible to residents and visitors. The facility will make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law.**	**05/07/2016**

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F 356	Continued From page 8 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the actual hours worked for licensed nursing staff directly responsible for resident care per shift on a daily basis. The facility also failed to maintain the posted daily nurse staffing data for a minimum of 18 months. These failures had the potential of not allowing resident family members or visitors to determine the workload of the staff caring for their loved-one. Findings: An inspection of the facility "physical plant" was conducted on 4/7/16 at 8:10 a.m. Included in the inspection was the facility's provision of Federally required informational postings. The inspection revealed the facility did not post the total number and actual hours worked by licensed nursing staff directly responsible for resident care per shift for the day of the inspection. An interview was conducted with Licensed Nurse (LN) 1 was on 4/7/16 at 8:20 a.m. LN 1 stated the daily licensed nurses roster used to be posted on the wall. LN 1 pointed to a location on the wall	F 356	**Director of Nursing or designee is posting staffing information as required. Daily postings are being maintained by the Director of Nursing for review.** **To ensure that staffing information is readily available, and accessible to future residents and visitors, Administrator reviewed facility policy with Director of Nursing and Nursing Supervisors to ensure that posting is completed and maintained for review. The Administrator or designee will monitor posting daily 7 days each week for one month to ensure that postings are maintained as required. If good compliance, monitoring will be reduced to monthly review of documentation to ensure continued compliance.**	**05/07/2016**

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F 356	Continued From page 9 across from Station 2. LN 1 stated the posting was taken down when Maintenance started painting. LN 1 stated the posting board was never put back up. An interview was conducted with the Director of Nurses (DON) was on 4/7/16 at 8:30 a.m. The DON stated she was not currently posting the daily roster of licensed nurses. The DON stated she had not maintained 18 months of the posted daily nurse staffing data.	F 356	**F 364** **Temporary and Permanent Correction** **It is the policy of this facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.**	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food was held at proper temperatures to maintain safety and palatability for 1 of 2 random residents (25). This failure had the potential for the service of unpalatable and potentially hazardous food. Findings: Observation of Station 3's medication room was conducted on 4/7/16 at 9:30 a.m. A resident breakfast tray was noted sitting on the counter in the medication room. A cup of milk and a cup of juice were covered with napkins. The plate contained two pieces of toast and there was a	F 364	**Resident 25 will have her tray held in the kitchen, if unable to be delivered, so that it can be maintained at the proper temperature.** **To ensure that all future residents are provided their food in a manner that complies with facility policy including serving food trays at the proper temperature, an inservice will be provided by the Staff Development Coordinator to all Direct Care Staff that covers facility policy to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.**	**05/07/2016**

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F 364	Continued From page 10 bowl of cold cereal. An interview was conducted with Licensed Nurse (LN) 2 on 4/7/16 at 9:35 a.m. LN 2 stated the breakfast tray in the medication room was being held for Resident 25. LN 2 stated Resident 25 got up late and staff would hold her breakfast for her in the medication room until she woke up. LN 2 stated they would heat up the food in the microwave. An interview was conducted with the Dietary Service Supervisor (DSS) on 4/7/16 at 9:45 a.m. The DSS stated the resident's tray should not be held for later delivery because proper temperatures could not be maintained. The DSS tested the temperature of both the milk and orange juice on Resident 25's tray. The milk was 63° Fahrenheit and the orange juice was 63.6° Fahrenheit. Both were more than 20° over proper holding temperature. The DSS acknowledged the food was not held at proper temperature.	F 364	**Dietary Manager will monitor tray delivery 5 days each week for one month to ensure that good compliance is maintained. If good compliance, monitoring will be reduced to monthly surveillance of tray delivery by the Dietary Manager, and the Dietician that is reported to the Quality Improvement Committee for continued compliance.**	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F 441** **Temporary and Permanent Correction** **It is the policy of this facility to 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.**	**05/07/2016**

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F 441	Continued From page 11 (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 and staff interview, the facility failed to process linens in a manner to prevent the spread of infection. This failure had the potential to contaminate linens/laundry with potentially infectious material. Findings: An inspection of the facility laundry department was conducted on 4/6/16 at 1:30 p.m. Two soiled laundry barrels were positioned approximately two feet from two washing machines. Both washing machines contained a load of laundry	F 441	**Housekeeping Supervisor immediately discussed facility policy to keep soiled linen separated from clean linen, including that soiled linen barrels should not be near the washing machine when linen is being washed. Impermeable garment was provided to laundry worker.** **To ensure that future residents are protected possible infection and that linens are processed in a manner to prevent the spread of infection. Inservice will be provided to housekeeping and laundry staff, by the Administrator, that covers facility policy on processing linens in safe and sanitary and comfortable environment, including using impermeable garment when transferring linens and separating clean and soiled linens to prevent transmission of disease and infection.**	05/07/2016

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	056495	A. BUILDING _____ B. WING _____	04/07/2016

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F 441	Continued From page 12 that was being washed. The two laundry barrels were completely full with soiled laundry. On top of the soiled laundry barrels were loosely place lids resting on top of soiled laundry partially protruding from the barrels. Laundry Staff (LS) 1 was asked to explain the procedure she would follow if the laundry in the washing machines had finished and was ready to be processed for drying. LS 1 pointed to an empty laundry cart (approximately 2 feet wide by 4 feet long) and stated she would empty the clean laundry into the cart, wheel the cart to the dryers, then load the dryers with the clean laundry. When asked if there was anything she would do prior to taking the clean laundry from the washers and placing them into the laundry cart, LS 1 stated, "No." When asked about the soiled linen barrels, LS 1 stated the soiled linen barrels should not be in the washing machine area when laundry was being washed. A concurrent interview was conducted with LS 1. She was asked if she wore a protective gown when she processed the soiled linens from the soiled linen barrels. LS 1 pointed to a fabric/cotton smock hanging on a hook. LS 1 demonstrated how she donned the smock and pointed out it was okay to use because it had long sleeves. When asked if the smock was impermeable to liquid/moisture, LS 1 stated she didn't know. An interview was conducted with Maintenance Staff (MS) 1 on 4/7/16 at approximately 9:30 a.m. MS 1 stated the fabric/cotton smock used by the laundry staff was not impermeable to liquids/moisture. He stated he was ordering new gown that were impermeable to liquids/moisture.	F 441	**Administrator will monitor linen processing 5 days each week for one month. If good compliance is maintained, monitoring will be reduced to monthly surveillance that is conducted by Housekeeping Supervisor and provided to the Infection Control Committee to ensure continued compliance.**	

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F 458	Continued From page 13	F 458		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	F 458		

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, staff interview, resident interview, and facility document review, the facility failed to ensure there was at least 80 square feet (sq. ft.) of living space per resident in 32 resident bedrooms. This failure had the potential to result in a lack of privacy and inadequate space for provision of care.

Findings:

The required square footage for each of the 32 resident bedrooms provided less than 80 sq. ft. per resident.

Room	Beds	Square Feet Per Room	Per Resident
21	3	218.4	72.8
22	3	218.4	72.8
23	3	218.4	72.8
24	3	218.4	72.8
25	3	218.4	72.8
26	3	218.4	72.8
27	3	218.4	72.8
28	3	223.9	74.6
29	3	218.4	72.8
31	3	219.6	73.2
32	3	220.8	73.6
33	3	219.6	73.2
34	3	220.8	73.6

Request continued Waiver. **05/07/2016**

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F 458	Continued From page 14	F 458		

35	3	219.6	73.2
36	3	220.8	73.6
37	3	226.9	75.6
38	3	226.3	75.4
40	3	230.2	76.7
42	3	217.2	72.4
43	3	220.8	73.6
44	3	217.2	72.4
45	3	220.8	73.6
46	3	217.2	72.4
47	3	220.8	73.6
48	3	217.2	72.4
49	3	220.8	73.6
53	3	218.4	72.8
55	3	218.4	72.8
56	3	218.4	72.8
57	3	218.4	72.8
58	3	225.7	75.2
59	3	225.7	75.2

Observations revealed the residents had a reasonable amount of privacy and storage space. The rooms were clutter free and there appeared to be adequate space for residents to ambulate. Residents had clear access to the bathroom and exit doors. There was sufficient room for the provision of nursing care and services.

During random interviews with staff and residents, there were no complaints regarding inadequate space.

The Department recommends the room waiver be granted.

F 468 SS=E — 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

The facility must equip corridors with firmly

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F 468	Continued From page 15 secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to equip corridors with firmly secured handrails. This failure had the potential to contribute to accidents or incidents involving unsuspecting residents, staff, or visitors grasping the handrails for support. Findings: An inspection of the facility "physical plant" was conducted on 4/6/16. The inspection revealed loose handrails located in the hallway between the door to the facility kitchen and room number 56, and in the hallway to the left of the door to facility laundry. An interview was conducted with Maintenance Staff (MS) 1 was on 4/7/16 at 9 a.m. MS 1 stated they recently became aware of the loose handrails and were repaired.	F 468	**F468** **Temporary and Permanent Correction** **It is the policy of this facility to equip corridors with firmly secured handrails on each side of hallway.** **Maintenance immediately replaced brackets identified to ensure handrail was firmly secured.** **To ensure that future residents are provided with handrails that hare firmly secured on each side of the hallway. Administrator will monitor handrails weekly for one month to ensure that handrails are in good repair. If good compliance is maintained, monitoring will be reduced to monthly surveillance that is conducted by the Maintenance Supervisor and reported to the Administrator of continued compliance.**	
F 516 SS=B	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 516		

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F 516	Continued From page 16 The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safeguard clinical record information against unauthorized use when the medical records office was left unsecured and unattended. This failure had the potential for resident clinical record information to be vulnerable to unauthorized access and use. Findings: The facility medical records office was observed with the door propped open and unattended by any facility staff on 4/6/16 at 6:45 a.m. An interview was conducted with Medical Records Staff (MRS) 1 on 4/6/16 at 6:50 a.m. regarding the safeguarding of clinical record information. When asked about the medical records office being left unsecured and unattended, MRS 1 stated she was not aware of a requirement the medical records office be locked when she was away.	F 516	**F516** **Temporary and Permanent Correction** **It is the policy of this facility not to release information that is resident-identifiable to the public. Administrator immediately informed Medical Records staff that door must be secured when she is not in the office. Medical Records staff expressed that she understood facility policy to safeguard clinical record information against unauthorized use.** **To ensure that all present and future residents' records are safeguarded, Administrator provided inservice to all staff using offices that contain resident information. Inservice covered facility policy to safeguard medical records including securing offices when not in office.** **Administrator will monitor offices 5 days each week for one month. If good compliance is maintained, monitoring will be reduced to monthly surveillance that is completed by Administrator and reported to the Quality Improvement Committee for continued compliance.**	**05/07/2016**

Accepted 5-12-16 AW