STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555613	A. BUILDING _____ B. WING _____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

(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 Re-certification Survey conducted on December 28 through December 31, 2015. Representing the California Department of Public Health: Surveyor 35229, HFEN Surveyor 33234, HFEN Surveyor 25624, HFEN The facility census was 28. There were no bedholds. The sample size was 10 residents.	F 000	**This document will serve as a credible allegation of our intent to correct deficient practices identified. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code.**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure oxygen was not administered for one of ten sampled residents without a physician's order (Resident 9).	F 309	**F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Director of Nursing (DON) contacted the physician of Resident 9 immediately and the physician provided a new order for oxygen as needed (PRN). ***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;***	

APOC 2/2/16 MCHC HFES

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RIVERSIDE COUNTY

CA DEPT OF PUBLIC HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Matthew Turner | Administrator | 1/25/16

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 309	Continued From page 1 This facility failure increased the potential for the resident to receive oxygen or other medications without the physician being aware. Findings: On December 28, 2015, at 9:55 a.m., the initial tour was conducted with the Director of Nurses (DON). Resident 9 was observed lying in bed receiving oxygen flowing at one and a half liters via nasal cannula (a tube use to delivers oxygen). In a concurrent interview with the DON, he verified the oxygen setting. On December 29, 2015, at 8 a.m., the record for Resident 9 was reviewed with Registered Nurse 2 (RN 2). Resident 9 was admitted to the facility on December 18, 2015, with diagnoses that included chronic obstructive pulmonary disease (COPD, a respiratory disease). The record did not include an order for oxygen administration. During a concurrent interview with RN 1, she stated she did not see a physician's order for Resident 9's oxygen.	F 309	~~No other residents were found to be~~ impacted by the practice. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** Upon arrival of a new, admitting resident, admitting nurse will review transfer orders from transferring facility and verify oxygen saturation levels of the resident. If oxygen is required and not outlined in the transfer orders from the transferring facility, admitting nurse will contact physician to receive orders as necessary. The facility Director of Staff Development (DSD) will in-service all licensed staff on process for admitting new residents, verifying oxygen saturation levels, and requesting physician orders. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;***	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	DON/Charge Nurse will conduct daily check of residents utilizing oxygen therapy and verify that physician are in place accordingly. DON/Charge Nurse will maintain a log book at the nurses station for documenting completion of daily checks. Medical Records will audit logbook and report to QA on a monthly basis.	

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F 315	Continued From page 2 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to conduct a bowel and bladder assessment, initiate bladder training, and a toileting program for one of 10 sampled residents (Resident 11). This facility failure resulted in missed opportunities to improve the resident's bladder function. Findings: On December 28, 2015, Resident 11's record was reviewed. The resident was admitted to the facility on December 11, 2015, with diagnoses which included chronic kidney disease, history of falling, and dementia (memory loss). A review of Resident 39's admission assessment titled, "Bowel and Bladder Assessment," dated December 11, 2015, indicated, "Continent as defined by staff resident had an indwelling catheter." A review of an physician order, dated December 14, 2015, indicated, "Bladder training x (times) 2 (two) days then discontinue Foley catheter." Resident 11's indwelling catheter was removed on December 17, 2015. There was no indication of a bladder training times two days was conducted prior the removal of the indwelling catheter. There was no indication a bowel and bladder assessment was	F 315	***Date when corrective actions will be completed:*** 1/28/2016 **F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER** ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** The records for Resident 11 were reviewed and the resident was placed on a bowel and bladder retraining program on December 28, 2015. ***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 other residents were found to be impacted by the practice. ***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 facility Director of Staff Development (DSD) will in-service all licensed staff on completing a bowel and bladder assessment after removal of foley catheter and on implementing bowl and bladder retraining program if resident is having episodes of incontinence.	

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F 315	Continued From page 3 conducted after the removal of the indwelling catheter. There was no indication a toileting program was initiated. During an interview conducted with Resident 11's daughter on December 29, 2015, at 2:10 p.m., she stated the facility staff did not offer Resident 11 the opportunity for toileting every two hours. During an interview with Certified Nursing Assistant 1 (CNA 1), who was assigned to Resident 11, on December 28, 2015 at 2:10 p.m., she stated Resident 11 was not on any toileting program. During an interview conducted with the Director of Nursing (DON) on December 28, 2015, at 4:10 p.m., he stated the licensed nurse should have conducted a bowel and bladder assessment when they discontinued the indwelling catheter. The DON further stated Resident 11 should have been placed on a toileting program. The facility policy and procedures titled, "Bowel and Bladder Assessment," dated May 2013, was reviewed. The policy and procedure indicated, "...3. The interdisciplinary team (IDT) will identify if the resident is a candidate for the bowel and bladder retraining program, and ...5. Residents will be re-evaluated by the IDT quarterly and when a significant change occurs."	F 315	The DON will also create an alert on the facility electronic management record (EMR) that will alert licensed staff of removal of foley catheter from residents when discontinued and need for completing subsequent bowel and bladder assessment. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** DON will monitor the alerts on the EMR for completion and report any incomplete assessments from the EMR log to the QA on a monthly basis. ***Date when corrective actions will be completed:*** 1/28/2016	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325	**F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** ***How corrective action(s) will be accomplished for those residents found to***	

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F 325	Continued From page 4 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of ten sampled resident (Resident 11) received Med Plus 2.0 (liquid nutritional supplement) per physician orders when the resident's intake was less than 50% (percent) per meal. The facility's failure to ensure Resident 11 received the nutritional supplement per physician's orders, increased the potential for the resident's weight loss, malnutrition, dehydration, and a resulting decline in condition. Findings: On December 28, 2015, Resident 11's record was reviewed. The resident was admitted to the facility on December 11, 2015, with diagnoses that included right hip fracture, chronic kidney disease and dementia (a memory loss). On December 28, 2015, at 12:25 p.m., during lunch observation, Resident 11 was observed consuming only the milk on her lunch tray. The facility documented 0-25% of total lunch consumption. During a concurrent interview conducted with Resident 11, she stated she only	F 325	~~*have been affected by the deficient practice;*~~ IDT met with the Registered Dietician (RD) for Resident 11 to review Resident 11's orders. RD removed restrictions for when to offer Med Plus 2.0 and revised order to offer supplement between meals 3x/day. ***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 other residents were found to be impacted by the practice. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** DON will review RD orders weekly with the Dietary Supervisor and add alerts to EMR system for licensed staff to offer supplements per RD orders/physician orders. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** DON will monitor the alerts on the EMR for completion and report any incomplete	

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F 325	Continued From page 5 liked to drink liquid or milk. On December 29, 2015, the "Order Summary Report," dated December 24, 2015, was reviewed. The document indicated, "MED PLUS 2.0 every 5 hours as needed for POOR intake (low food intake) TID (three times a day) PRN (as needed), GIVE 120CC (milliliter) IF < (less than) 50% (percent) OF MEALS CONSUMED." A review of the resident's meal intake was conducted, the document indicated as follows: - December 24, 2015, breakfast, lunch and dinner = 0-25%; - December 25, 2015, breakfast, lunch = refused, dinner = 26%-50%; - December 26, 2015, breakfast and lunch = 26%-50%, dinner = 26%-50%; - December 27, 2015, breakfast = 26%-50%, lunch and dinner = 0-25% and; - December 28, 2015, breakfast, lunch and dinner = 0-25%. There was no documented evidence "MED PLUS 2.0" was given to Resident 11 when she refused meals or when her meal intake was less than 50%, as per physician order. During an interview conducted with the Director of Nursing on December 30, 2015, at 2:15 p.m., he stated the licensed nurses should have given the Med Plus 2.0 every time the resident refused a meal or if her meal consumption was less than 50%.	F 325	assessments from the EMR log to the QA on a monthly basis. ***Date when corrective actions will be completed:*** 1/28/2016	

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F 325	Continued From page 6 The facility policy and procedure titled, "Supplements," dated May 2013, indicated, "...It is the policy of this facility that medically indicated commercial supplemental feedings will be instituted when determined necessary based on nutritional assessment by the Registered Dietician (RD) and prescribed by a physician."	F 325		
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 record review, the facility failed to prepare, store, serve, and distribute resident's food under sanitary conditions when: 1. Three plastic bins of cereal were opened and unlabeled with a use by date; 2. The Nurti-juice dispensing nozzle labeled ,"Fiber Drinks," was noted with a sour odor on the tip; 3. The wooden kitchen entry door was observed with a separation of laminate layers exposing the	F 371	**F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** 1. The plastic bins were immediately closed and labeled with use by date. 2. The nozzle was immediately removed and cleaned 3. The door was immediately replaced with a new door that sealed tightly 4. The kitchen screen was immediately cleaned 5. The drains pipes were shortened in order to maintain an air gap. ***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;*** All residents were found to potentially be impacted by the practice. ***What measures will be put into place or what systemic changes the facility will***	

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F 371	Continued From page 7 internal crumbling fiber board core and creating a gap of approximately one half inch at the top and bottom of the door allowing space large enough for vermin to enter the kitchen. 4. The internal kitchen metal screen door was observed with an accumulation of dust and grime that became airborne when wiped with a paper towel; and 5. Three kitchen floor sink drains did not maintain an air gap (space between the bottom of the pipe draining into the drain and the rim of the drain) to prevent potential contamination in the event of a negative water pressure. The walk in refrigerator drain pipes, the steam table drain pipes and the dishwashing drain pipes were noted as having the drain pipes routed to the floor style drain extending down into the drain at or below the level of the floor. This failed practice had the potential to result in food borne illness in a medically vulnerable resident population of 28. Findings: 1. During the initial kitchen tour on December 28, 2015, with the Dietary Manager (DM), three opened plastic food bins containing breakfast cereal were observed labeled with the date opened. No use by or expiration date were located on the bins. The cereal bins were labeled and dated as follows: "rice cereal 11-23-15; raisin bran 11-23-15; and corn flakes 11-17-15." When asked how long the cereal is to be held before it expired, Cook 1 stated, "It is good for one week or maybe one month." Cook 1 also	F 371	~~*make to ensure that the deficient practice does not recur;*~~ 1. Dietary Supervisor (DS) will in-service kitchen staff on dating opened items and conduct daily rounds checking for unlabeled items. 2. DS will contract with dispenser manufacturer to conduct cleaning on nozzles per a written schedule from manufacturer. 3. DS will in-service kitchen staff on adding maintenance repair requests to maintenance log maintained in kitchen. Maintenance staff will review maintenance log daily and make repairs as noted. 4. DS will add routine cleaning of metal door to kitchen daily cleaning checklist and monitor for completion. 5. Maintenance staff will measure gaps of all drain pipes for proper clearance and repair clearances as needed. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** 1. DS will maintain log and report incidents of unlabeled items to the QA on a monthly basis. 2. DS will report incidents of incomplete cleaning per written schedule by dispenser manufacturer to the QA on a monthly basis. 16 JAN 25 AM 10:56 RIVERSIDE COUNTY CLERK & CERTIFIED CA DEPT OF PUBLIC HEALTH	

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F 371	Continued From page 8 confirmed the cereal bins were only labeled with the date opened. Concurrently, Dietary Aide 1 (DA1) was asked when the cereal expires and she stated it expires in one week and the cereal is only labeled with the date opened. During a concurrent interview with the DM, he confirmed the bins should also be labeled with an expiration date. On December 28, 2015, the facility's undated food expiration policy was reviewed. The policy indicated, "Once food product is opened or used, a food rotation sticker must be used to indicate food item, date opened and use by date." 2. During the initial kitchen tour on December 28, 2015, with the Dietary Manager (DM), the Nutri-juice dispensing nozzle labeled, "Fiber Drinks" was noted with a sour odor on the dispensing tip. During a concurrent interview the DM stated the fiber drink nozzle was rarely used. The DM also stated the juice dispensing nozzles were cleaned every night, but there was no written cleaning schedule for the juice machine indicating it had been cleaned. A concurrent review of the manufacturer's preventive maintenance schedule indicated the date of last machine cleaning was December 14, 2015. A review of the undated facility document titled, "Nutri-Juice Equipment Cleaning Procedures," indicated, "You may do any daily cleaning you feel	F 371	3. Maintenance will report any incomplete maintenance items from the log to QA on a monthly basis. 4. DS will maintain a log of daily cleaning checklist and report cleaning results to QA on monthly basis. 5. Maintenance will report on completion of drain pipe shortening/air gap clearance at next QA meeting. ***Date when corrective actions will be completed:*** 1/28/2016	

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F 371	Continued From page 9 necessary such as wiping down the unit and cleaning the nozzle(s). We do not recommend soaking the gun overnight. Just Rinse and wipe off." 3. During initial kitchen tour on December 28, 2015, with the Dietary Manager (DM), the outside wooden kitchen entry door was observed with a separation of laminate layers exposing the crumbling internal fiber board core and creating a gap of approximately one half inch at the top and bottom of the door allowing a space large enough for vermin to enter the kitchen. During a concurrent interview, the DM stated the wooden door was left open for the vendors to have access and becomes wet when it rains. DM stated the condition of the door was reported to maintenance in a meeting, but the DM had nothing in writing confirming the discussion. DM confirmed the screen door was bent at the bottom exposing a small gap. A review of the maintenance log was conducted on December 30, 2015. There was no entry for the requested repair of the kitchen door noted. A review of the facility policy and procedure dated 2014, titled, "Storage of Food and Non-Food Supplies," indicated, "... C. The storeroom is protected against rodents and insects. 1) There are no exposed cracks or holes in the walls, ceilings or floor." 4. During the environmental tour in the kitchen on December 30, 2015, with the Maintenance Director and the Dietary Manager (DM), the internal kitchen metal screen door was observed with an accumulation of dust and grime that	F 371		

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F 371	Continued From page 10 became airborne when wiped with a paper towel. During a concurrent interview, the DM stated the wooden kitchen door was left open for the vendors to have access and for ventilation, but the screen door was kept closed. The DM confirmed the screen door was dirty and indicated there is no cleaning schedule for the screen door. The DM stated, "We try to keep it clean but it's dirty now. There is no one currently assigned to clean it." During a concurrent interview, the Maintenance Director confirmed the screen door was dirty and stated his department was not assigned to clean the internal screen door. On December 30, 2015, the facility policy and procedure dated "2014", and titled, "Dietetic Services Cleaning Walls and Ceilings," was reviewed. The policy and procedure indicated, "Wall surfaces and ceilings will be cleaned by dusting with a mop or vacuum, washed with hot detergent solution, rinsed and allowed to air dry." 5. During initial kitchen tour on December 28, 2015, with the Dietary Manager (DM), three kitchen floor sink drains did not maintain an air gap (space between the bottom of the pipe draining into the drain and the rim of the drain) to prevent potential contamination if a negative water pressure event was to occur. The walk in refrigerator drain pipes, the steam table drain pipes, and the dishwashing drain pipes were noted as having the drain pipes routed to the floor style drain extending down into the drain at or below the level of the floor. During a concurrent interview, the DM stated he	F 371		

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F 371	Continued From page 11 did not know the drain pipes couldn't be down in the drain and he would have to contact maintenance for direction. On December 30, 2015, during the environmental tour in the kitchen, the Maintenance Director confirmed all three floor style drains had pipes terminating at the level of the floor or below. According to the 2013 FDA Food Code, an air gap between the water supply inlet (pipe) and the flood level rim of the plumbing fixture, equipment, or non-food equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch. An air gap prevents the possible backflow of waste water into the steam table and the ice machine in the event of negative water pressure.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically 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	F 431	**F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Items 1 & 2 – DSD in-serviced all licensed staff on proper controlled medication reconciliation and medication disposal per facility policy. Item 3 – The medication cart was immediately locked and attended. ***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;***	

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	555613	A. BUILDING _____ B. WING _____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

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F 431	Continued From page 12 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure: 1. Records of controlled medication inventory were reconciled by two licensed nursing staff at the end of each shift for nine shifts from May 1, 2015, through December 29, 2015; 2. Records of non-controlled medication drug disposition log were disposed and witnessed by two licensed nursing staff on December 13 and 26, 2015; and 3. Intravenous (IV) medication cart were locked and supervised. These failures increase the potential for residents to not receive physician ordered medications due to medication loss and diversion.	F 431	Multiple residents were found to potentially be impacted by the practice. ***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. DSD conduct in-service with all licensed staff on drug reconciliation before/after each shift. DON or designee will review completion of drug reconciliation for each cart on a daily basis. 2. DSD will conduct in-service with all licensed staff on policy for drug disposition. DON or designee will review completion of drug disposition on a daily basis. 3. DSD will in-service all licensed staff on medication storage in the facility and attending/locking all IV/medication carts. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** 1. DON will report drug reconciliation log to QA committee on a monthly basis. 2. DON will report drug disposition log to QA committee on a monthly basis. 3. DON/designee will monitor locking of IV/Medication carts and rooms and	

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F 431	Continued From page 13 Findings: 1. On December 29, 2015, at 9:10 a.m., during the medication cart inspection with Licensed Vocational Nurse 1 (LVN 1), the "Narcotic Check Sheets," were noted to have empty signature spaces on the following: a. May 2, 2015, 7-3 shift; b. May 13, 2015, 7-3 and 3-11 shift; c. June 19, 2015, 7-3 shift; d. September 26, 2015, 7-3 shift; e. September 30, 2015, 3-11 shift; f. October 3, 2015, 7-3 shift; g. November 2, 2015, 7-3 shift; h. November 29, 2015, 7-3 shift; i. December 11, 2015, 7-3 shift; and, j. December 23, 2015, 3-11 shift. In a concurrent interview with LVN 1, she stated there should be two nurse's signatures every time the nurses counted the narcotic before and after each shift. During an interview conducted with the Director of Nursing (DON) on December 30, 2015, at 9:15 a.m., the DON stated the "Narcotic Check Sheets," should be signed by the outgoing and incoming nurses every time after they counted the narcotics. The policy and procedure titled, "Narcotic Count," dated November 2007, indicated,"...1. One RN (Registered Nurse) or LVN/LPN (Licensed Vocational Nurse/Licensed Practical Nurse) going off duty and one RN or one LVN/LPN coming on duty must count and justify narcotic supply for each individual resident at the change of each shift..."	F 431	~~report incidents of~~ unattended/unlocked carts to QA on a monthly basis. ***Date when corrective actions will be completed:*** 1/28/2016	

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F 431	Continued From page 14 2. On December 29, 2015, at 10:20 a.m., during the medication storage inspection. A review of the "Drug Disposition Log, Non-Controlled Medication," noted there was not two licensed nurses' signatures on December 13 and 26, 2015, when the nurse disposed of or returned the medications to the pharmacy. On December 29, 2015, at 10:30 a.m., an interview was conducted with the Director of Nursing (DON). He stated two licensed nurses signatures should be on the "Drug Disposition Log" to signify they counted and witnessed the medications during the drug disposition. In a concurrent interview with LVN 1, she stated she forgot to sign the "Drug Disposition Log." She further stated, she was the one who disposed of the medications on December 13 and 26, 2015. She stated she forget to sign the disposition log and no one else assisted her during the disposition procedure. A review of an undated facility policy and procedure titled, "Medication Destruction," indicated, "...4. Medication destruction occurs only in the presence of 2 (two) licensed people (e.g. facility Administrator, licensed nurses or a pharmacist)." 3. On December 29, 2015, at 2:40 p.m., during the IV medication cart inspection, the IV medication cart was observed unlocked and unsupervised. The content of the cart include, syringes, sharps, and 13 multiple IV antibiotics medications. In a concurrent interview with the DON, he	F 431		

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F 431	Continued From page 15 confirmed the IV medication cart was unlocked and unsupervised. He further stated he forgot to lock the IV medication cart after he used the IV cart. A review of undated facility policy and procedure titled, "MEDICATION STORAGE IN THE FACILITY," indicated, "...3. Medication rooms, medication carts, and medication supplies are locked or attended by persons with authorized access."	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 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	F 441	**F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** The contaminated dressing was removed by the DON and a new dressing applied to Resident 19's wound. ***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 other residents were found to be impacted by the practice. ***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 facility Director of Staff Development (DSD) will in-service all licensed staff on	

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F 441	Continued From page 16 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 proper hand hygiene was followed by Registered Nurse 1 (RN 1) during wound care for one of ten sampled residents (Resident 19). This failed practice had the potential to result in the spread of infectious bacteria which can cause severe illness in an already medically fragile population. Findings: On December 29, 2015, at 10:15 a.m., RN 1 and the Director of Staff Development (DSD) were observed performing wound care with a dressing change for Resident 19. During the dressing change observation, RN 1 was observed removing the soiled coccyx (tailbone area) wound dressing from Resident 19. After removing Resident 19's soiled wound dressing, RN 1 changed her gloves, but did not wash her hands. RN 1 then proceeded to apply clean dressings to	F 441	~~proper infection control procedures when~~ providing wound care treatments. Facility skin committee will meet with third-party wound care consultant monthly to review wound care techniques and evaluate treatment procedures of wound care nurses, including infection control practices. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** DON will report changes of condition, wound healing progression, and skin committee meeting minutes to QA on a monthly basis. ***Date when corrective actions will be completed:*** 1/28/2016	

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F 441	Continued From page 17 Resident 19's wound. While securing the dressing to Resident 19's skin, using her gloved hand, RN 1 pulled a pair of scissors out of her pocket. Without cleaning the scissors, RN 1 cut the adhesive tape, then applied the tape to Resident 19's skin. During an interview conducted with RN 1 on December 29, 2015, RN 1 stated hands should be washed after touching dirty wound dressings and before touching anything clean. When asked if she washed her hands after removing Resident 19's soiled dressing, RN 1, stated, "No." During a concurrent interview, the DSD confirmed RN 1 should have washed her hands after removing the dirty wound dressing and before starting to apply the clean dressing. DSD also stated RN 1 should not have used scissors from her pocket. The DSD also stated the proper scissors to use during a dressing change are provided in the wound supply cart. If personal scissors were used, then they should be properly cleaned first. On December 29, 2015, a review of the facility Policy and Procedure dated May, 2013, titled, "Dressing, Clean," indicated, "7. Remove soiled dressing ... 8. Remove old adhesive ... 9. Wash hands and apply clean gloves. 10. Cleanse wound ..."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	**F 465 483.70(h)** **SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT** ***How corrective action(s) will be accomplished for those residents found to***	

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F 465	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain residents' environment in a safe and sanitary manner. Findings: During the initial tour on December 28, 2015, at 8:45 a.m., with the Director of Nursing (DON), the following was observed: 1. The plumbing access panel door was not securely closed for resident rooms 204, 205, 207 and 217. 2. The bathroon sink for resident rooms 202 and 205 was not securely attached to the wall and the chaulking was displaced. 3. For resident rooms 202 and 205, the plate behind the tub faucet handle was not secured. It was easily moved, which revealed a large hole in the wall under the plate. 4. In resident room 203, the bathroom sink had a hole. 5. In resident bathroom for resident 203 there was a hole in the wall under the sink. 6. The call light panel on the wall for resident room 205 bed A was not properly secured. 7. Resident room 204 bathroom had a can light which was partially hanging from the ceiling.	F 465	~~*have been affected by the deficient practice;*~~ All 8 items were repaired immediately. ***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;*** Multiple residents were found to potentially be impacted by the practice. ***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 facility Director of Staff Development (DSD) will in-service all staff on reporting maintenance issues/repairs to maintenance staff utilizing the maintenance logs at the nurses station and in the kitchen. Maintenance staff will conduct daily checks of all maintenance logs and complete repairs within 24 hours or as soon as practicable. Maintenance will conduct daily rounds of each room and update completion of rounds in the maintenance log book. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;***	

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F 465	Continued From page 19 8. Resident bathroom 207 door knob was loose and unsecured. In a concurrent interview with the DON, he stated, "These things need to be repaired."	F 465	~~Maintenance supervisor will report~~ maintenance repairs and outstanding repairs to QA on a monthly basis. ***Date when corrective actions will be completed:*** 1/28/2016	