STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 RECERTIFICATION SURVEY. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 22934 Health Facilities Evaluator Nurse 34688 Health Facilities Evaluator Nurse 35370 Health Facilities Evaluator Supervisor 21052 Public Health Nutrition Consultant 27157 Public Health Pharmaceutical Consultant 25281 The census in the facility during the survey was 44 residents. The resident sample size was 11 residents, which represented the total universe for the purposes of scope and severity determination. During the survey one ERI (entity reported event) CA00432043, was investigated and exited with the survey. No deficiency was issued for ERI CA00432043.	F 000	*Presidio Health Care Center submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employee, agents, officers, directors, or shareholders.* *The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.* *Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceedings on that basis.* MAR 10 2015 NV 3/2/15	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	CK by Surveyor	

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

[signature] | ADON | 3/18/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 279	Continued From page 1 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that care plans were developed, for 1 of 11 sampled residents (Resident 19), for Care Area Assessments (CAAs) that were identified in the resident's annual Minimum Data Set (MDS) assessment. Findings: Resident 19 was admitted to the facility with diagnoses that included the need for rehabilitation per the resident's Face Sheet. On 2/17/15 at 2:15 P.M. Resident 19 was observed resting on the bed, mouthing words that were not understandable, rocking back and forth, and watching TV. On 2/18/15 the record of Resident 19 was reviewed. An annual Minimum Data Assessment	F 279	**F 279** It is the intention of the facility to use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. ***How corrective action will be accomplished for those residents found to have been affected by the deficient practice;*** Resident 19 was reviewed and audited with DON, MDS Nurse, and Nurse Consultant. Resident has all proper care plans in place. All CAA triggered in the MDS assessments have proper care plans and documentation. On 02/19/15 MDS Consultant conducted an in-service to all MDS nurses regarding facility policy and procedure for Care planning for re-admitted residents. ***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;*** DON, MDS Nurse, and Nurse Consultant reviewed all current residents care plans and CAA identified in the resident's MDS assessments. No other residents were identified by the deficient practice. ***What Measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not occur;***	3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 279	Continued From page 2 (MDS) dated , indicated that the assessment results had triggered care areas which included communication, behavioral symptoms, dental and pressure ulcer. Each of those areas indicated that a care planning decision had been made. Resident 19's care plans were reviewed. A care plan for communication dated , indicated it had not been reviewed since . The care plan indicated that resident 19 was edentulous (no teeth) and had a diagnosis of "aphasia" (inability to speak) and "selective mutism" (not speaking by choice). Review of Resident 19's care plan for dental care dated indicated that Resident 19 was edentulous, but required assistance due to impaired mobility and and problems. A care plan dated dated , indicated Resident 19 was at risk for skin breakdown due to impaired mobility and other conditions. The care plan had not been reviewed since . On 2/19/15 at 10 A.M. a joint record review and interview was conducted with the Director of Nursing (DON). The DON acknowledged that the communication, dental and skin care plans should have been maintained in the active record and updated and reviewed quarterly. The DON acknowledged that there was no for Resident 19 as indicated in the CAA's. The DON further acknowledged that where the CAA's triggered a care plan and a care planning decision was made, the care plans should have been developed and should have been reviewed and updated quarterly. The DON stated that if the care plans were no longer needed they	F 279	MDS nurse will review all care plans on the resident upon admission/re-admission. After each MDS assessment or quarterly assessment MDS nurse will audit and review each residents chart to ensure all applicable care plans are implemented. ***How the facility plans to monitor its performance to assure 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 and include dates when corrective action will be completed.*** DON and MDS consultant will review and audit care plans, CAA, MDS assessments of all readmitted patients once every month for 6 months. Findings and trends will be reported to the CQI/QA Committee for evaluation and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 279	Continued From page 3 should have indicated that they had been discontinued.	F 279	**F 325** It is the intention of the facility to maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem.	3/31/15
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 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 provide double protein portions during a meal, for 1 of 11 sampled residents (Resident 43). For Resident 43, the facility failed to provide a therapeutic diet consistent with Resident 43's physician's order, nutritional assessment, and the facility policy and procedure. This failure had the potential to place Resident 43 at risk for nutritional decline. Findings: Resident 43 was admitted to the facility on , per the facility's face sheet. Resident 43 was admitted to the facility with diagnoses which included anemia, end stage renal disease (kidney disease) on hemodialysis (machine that removes toxins from the kidneys) and protein calorie	F 325	***How corrective action will be accomplished for those residents found to have been affected by the deficient practice;*** On 02/18/15 DON & Registered Dietician reviewed resident 43's weight, meal percentages, for any trends or signs and symptoms of weight loss. Upon review resident has no signs and symptoms, trends of weight loss. ***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;*** On 02/18/15 DON & facility Registered Dietician reviewed all residents weights for the month of February that are on a Protein X2 diet for any potential sign and symptoms of weight loss. No other potential residents were identified. ***What Measures will be put into place or what systematic changes the facility will***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 325	Continued From page 4 malnutrition. Resident 43 "does not have the capacity to understand and make decisions" was indicated, per the the physician's History and Physical Examination, dated An observation of Resident 43's noon meal was conducted on on 2/18/15 at 11:45 A.M. Cook 1 was observed filling a 3 oz (ounce) ladle of chicken cacciatore onto the resident's plate, and then partially filled the same ladle to add to another portion of chicken cacciatore to Resident 43's plate. The tray card indicated: "Give Protein x [times] 2." A review of Resident 43's "Physicians Orders" dated ; was conducted. The physician's order indicated the following: "diet: mech [mechanical] soft renal CCHO [consistent carbohydrate diet] c [with] double protein portions." A joint interview and observation was conducted with dietician 1, on 2/18/15 at 11:48 A.M. The dietary tray was placed on the delivery cart and Dietician 1 was asked to remove the tray to check for diet accuracy. Dietician 1 stated: "Give Protein x 2" meant give 2, 3-oz scoops of protein. Dietician 1 verified that Resident 43's portion of chicken cacciatore as served by Cook 1, was less than the physician's ordered double portion of protein that it should have been. A review of Resident 43's "Nutritional Assessment," dated , was conducted. The nutritional assessment indicated: "Resident w/ [with] good po [by mouth] intake - on double portions." An interview was conducted with Dietician 1 on	F 325	***make to ensure that the deficient practice does not occur;*** On 02/18/15, Registered Dietician conducted in-services to all dietary staff on facility policy and procedures on Therapeutic diets. Registered Dietician and Dietary supervisor will do a skills check for all dietary staff focusing on serving therapeutic diets by 03/31/15. Dietary supervisor will continue to perform skills check once a month on all dietary staff for 6 months. ***How the facility plans to monitor its performance to assure 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 and include dates when corrective action will be completed.*** Administrator and Dietary supervisor will review skills check results every month. Administrator will report findings and trends to the QA/CQI Committee every month for evaluation and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 325	Continued From page 5 2/19/15, at 10:10 A.M. Dietician 1 stated that Resident 43 needed double protein portions, because was a dialysis patient and a lot of protein was removed during dialysis treatments. Dietician 1 further stated that, Resident 43's albumin (a protein in the blood) levels were low, and needed extra protein in diet. A review of the facility's undated policy titled: "Portion Sizes," was conducted. This policy indicated: "double portions are to be used for residents with high caloric needs who are eating well. The food server is to give 2 times the amount of the regular food portion for the main plate."	F 325		
F 371 SS=B	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 store and prepare food under sanitary conditions as follows: 1. Expired yogurt in a refrigerator with other food products 2. One freezer containing foods failed to meet the	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 371	Continued From page 6 required temperature for frozen foods 3. Raw chicken was observed on a shelf in the refrigerator above milk and near produce 4. A vent and filter located above a stove was covered in debris 5. A staff member was observed chewing gum during food preparation 6. A sanitizer bucket failed to meet the required sanitizer chemical concentration The above unsanitary practices in the food-service operation had the potential to place residents at risk for developing a food-borne illnesses. Findings: 1. A joint interview and observation of the refrigerator was conducted with the Cook 1 and Dietary Aide 1 (DA1) on 2/17/15 at 7:15 A.M. Two, 6 ounce cups of yogurt were observed on the top shelf of the refrigerator. Per the manufacturer's guidelines, the "use by" dates on the yogurt were 2/7/15 and 1/20/15. Cook 1 and DA 1 stated the yogurts are "expired." An interview was conducted with the Director of Nutritional Services (DNS) on 2/17/15 at 7:20 A.M. The DNS acknowledged that the yogurt was expired and should not have been stored in the refrigerator. A review of the facility's job description for the "Director of Nutritional Services," dated 12/12/14, was conducted. The document indicated that one of the DNS's principal responsibilities was: "Maintains a safe and sanitary working environment," and "Evaluates quality and quantity of services accomplished by staff." 2. A joint interview and observation was	F 371	**F 371** It is the intention of the facility to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions. ***How corrective action will be accomplished for those residents found to have been affected by the deficient practice;*** On 02/17/15 Expired yogurt in the refrigerator was discarded immediately. On 02/17/15 Freezer #1 was repaired by a third-party vendor and is now maintaining the proper temperature. A new Freezer was also purchased for additional storage. On 02/17/15 A third party vendor cleaned the kitchen hood, ducts, and exhaust. Vent and filter is now grease free. On 02/18/15 A third party vendor repaired and calibrated the sanitizer dispenser. It is now dispensing the proper concentration of sanitizer. ***What Measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not occur;*** On 02/18/15 Registered Dietician in-serviced all dietary staff on facility policy procedures for the following: 1. Food, Refrigerator and Freezer Storage	3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 371	Continued From page 7 conducted with the DNS (director of nutritional services) on 2/17/15 at 7:30 A.M. Three freezers were observed in a room containing multiple frozen food items. The freezers were labeled freezer #1, #2 and #3. The DNS was asked to check the temperature of freezer #1. The DNS stated the temperature of freezer #1 was 25 degrees (Fahrenheit). Freezer #1 contained bread rolls, a bag of pepperonis, ground cheese, 2 boxes containing 50, 4 oz healthshakes, strawberry slices, and 2 pie crusts. The healthshake boxes had directions that indicated: "keep 0° (degrees) F (Fahrenheit) or below." The DNS acknowledged that the healthshakes were soft and were not completely frozen. The directions on the package of pepperonis stated: "perishable, keep frozen." The DNS acknowledged that the pepperonis were soft to touch and were not completely frozen. A joint interview and observation was conducted with Cook 1 on 2/17/15, at 7:35 A.M. Cook 1 stated that she checked the temperatures of the freezers at 5:00 A.M. on 2/16/15, and documented the temperatures on the log. Cook 1 pointed at freezer #2 and #3 and stated she checked the temperatures on these freezers. Cook 1 stated she thought freezer #1 was a refrigerator, and because of that she had not been checking the temperature. A joint interview and document review of the facility's "freezer temperature log," dated February 2015, was conducted with Cook 1 and the DNS on 2/17/15, at 7:36 A.M. It was noted that, daily temperatures were recorded for freezer #1 and freezer #2. However, temperatures were not recorded for freezer #3. Cook 1 acknowledged she had not been checking the temperature of freezer #1 and had been documenting the temperatures of freezer #2 and	F 371	a. On 02/18/15 a food storage log was implemented. Dietary supervisor or Designee will monitor food storage compliance on a daily basis for one month. 2. Freezer Temperature Logging 3. Kitchen Hood Cleaning and Logging 4. Employee Dress Code 5. Sanitizer Bucket PPM Logging a. On 2/18/15 a sanitizer bucket PPM log was implemented. Concentration of sanitizer will be logged before each use. Registered Dietician and Dietary supervisor will do a skills check for all dietary staff focusing on Food storage, Freezer Temperature Logging, Kitchen Hood Cleaning, Employee Dress Code, Sanitizer Bucket PPM Logging by 03/31/15. Dietary Supervisor will continue doing skills check once a month on all staff for 6 months. ***How the facility plans to monitor its performance to assure 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 and include dates when corrective action will be completed.***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 371	Continued From page 8 freezer #3 on the wrong lines. The DNS acknowledged there were no temperatures recorded for freezer #1 on the freezer temperature log. An interview was conducted with the DNS on 2/17/15 at 10:30 A.M. The DNS stated that freezer #1 has been "on and off freezing," since December 2014. The DNS stated that he notified maintenance of the problem in December 2014. The DNS was unable to provide evidence of notification to maintenance and acknowledged that he never documented a problem with freezer #1's on and off freezing problem, on the Maintenance Log. A review of the facility's policy and procedure titled: "Procedure for Refrigerated Storage," dated March 2013, was conducted. The policy stated: "Freezer - 0° F or lower." An interview was conducted with the Director of Operations (DO), the Administrator in Training (AIT) and Dietician 1, on 2/16/15 at 10:03 A.M. The DO, AIT and D 1 acknowledged that freezer #1 was not meeting the required temperatures for freezing foods. 3. A joint observation and interview was conducted with the DNS (director of nutritional services) on 2/18/15 at 7:30 A.M. A pan of raw chicken was observed on a shelf in the refrigerator. The pan was located directly above gallons of milk and near produce. The DNS acknowledged the pan containing raw chicken should be on the bottom shelf of the refrigerator and not near produce. A review of the facility's policy titled: "Food Preparation," dated March 2013, was conducted. The policy indicated: "Store raw meat, poultry, and fish separately from cooked and ready-to-eat food to prevent cross contamination. Store cooked or ready-to-eat food above raw meat,	F 371	Registered Dietician and Dietary supervisor will do a skills check for all dietary staff focusing on Food storage, Freezer Temperature Logging, Kitchen Hood Cleaning, Employee Dress Code, Sanitizer Bucket PPM Logging by 03/31/15. Dietary Supervisor will continue doing skills check once a month on all staff for 6 months. Dietary supervisor will monitor and check Freezer Temperature Log, Kitchen Hood Cleaning Log, Employee Dress Code, and Sanitizer Bucket PPM Logs on a daily basis. Administrator will review and monitor skills check, Freezer Temperature Log, Kitchen Hood Cleaning Log, and Sanitizer Bucket PPM Logs once a week for 6 Months. Administrator will report findings and trends to the QA/CQI Committee for evaluation and further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 371	Continued From page 9 poultry, and fish, if these items are stored in the same unit. This will prevent raw-product juices from dripping onto the prepared food and causing food borne illness." 4. An joint observation and interview was conducted with Dietician 1, on 2/18/15 at 10:42 A.M. The vent and filter under the hood, above the stove, was observed with a large amount of dark colored substances, and was directly above the stove burners. Dietician 1 stated the dark substances was a buildup of grease on the vent and filter. The filter with a buildup of grease was located directly above prepared foods. A joint observation and interview was conducted with the DNS (director of nutritional services) on 2/18/15 at 12:27 P.M. The DNS acknowledged that the dark colored substance was a buildup of grease. The DNS also acknowleged that he was responsible for cleaning the vent and filter. A review of the facility's policy titled: "Hood and Filter - Operation and Cleaning," dated 10/1/14, was conducted. This policy stated: "Due to potentially high fire hazard, it is important that hood filters are part of the cleaning schedule and are kept free of grease and dust." 5. A joint observation and interview was conducted in the facility's kitchen on 2/18/15 at 11:37 A.M. The DNS (director of nutritional services) was observed chewing gum while preparing coffee, over cooked chicken and bread. The DNS acknowledged he should not have been chewing gum in the kitchen over foods that would be served to residents. An interview was conducted with the AIT (administrator in training) on 2/18/15 at 12:33 P.M. The AIT stated there should be no gum chewing in the kitchen, however, the facility had no policy stating that rule. 6. A joint interview and observation was	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 371	Continued From page 10 conducted with the DNS (director of nutritional services) on 2/18/15 at 3:04 P.M. A red colored bucket containing a cloudy liquid and a cloth rag, was observed under the sink. The DNS acknowledged that the cloth rag was used to clean surfaces in the kitchen. The DNS stated the liquid in the red bucket was to sanitize surfaces. The DNS stated he used a chemistry (chem) strip to check the ppm (parts per million) for the sanitizer, and it should be at 100 ppm to effectively sanitize. The DNS was observed to use a chem strip to check the sanitizer concentration in the red bucket. The DNS stated the concentration should reach 100 ppm. The DNS stated, "this bucket is not quite at100 ppm." The DNS estimated the concentration at 75 ppm, because he compared it to the color coded graph located on the sanitizer chem strip vial. The DNS also stated the facility did not keep a log for tracking the sanitizer concentrations. A joint interview and observation was conducted on 2/18/15, at 3:10 P.M. A review of the manufacturer's guidelines for the sanitizer in use indicated: "Thoroughly wet mobile surfaces with 1 ounce per 4 gallons of water (200 ppm) for a minimum contact time of 1 minute. Immerse mobile items in a solution of 1 ounce per 4 gallons of water (200 ppm) for a minimum contact time of 1 minute." The DNS acknowledged that the sanitizer in the red bucket did not meet the manufacturer's guidelines for sanitizer concentration of 200 ppm. A review of the facility's policy titled, "Quaternary Ammonium Log Policy," dated February 2010 was conducted. This policy indicated: "The concentration of the ammonium in the quaternary sanitizer will be tested at least once a day...The dietary worker will record the ammonium level on	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 371	Continued From page 11 the log prior to sanitizing the counters...be sure to mix the quaternary solution by following the directions on the container."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that medications were properly monitored before administration, when licensed nurse (LN) 1 left medications unattended at the bedside of one resident (Resident 47), during the medication pass. This action had the potential to result in an improper or incomplete medication administration	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 425	Continued From page 12 to Resident 47. Findings: Resident 47 was admitted to the facility with diagnoses that included the need for rehabilitation per the resident's Face Sheet. On 2/19/15 at 7:53 A.M., the room of Resident 47 was entered. LN 1 was outside of the room going through items located in the lower part of the medication cart. Resident 47's door was shut, and upon entering the resident's room, the privacy curtains were observed to be completely drawn around Resident 47. Resident 47 was observed sitting up in a chair having breakfast. A plastic medicine cup containing multiple pills was observed on the table next to Resident 47's breakfast tray. Resident 47 stated that the medications were not for self administration, but that LN 1 had left them there. On 2/19/15 at 7:56 A.M., LN 1 was observed in the hall with a blood pressure cuff. LN 1 acknowledged that she had left the medications at the bedside of Resident 47 while she went out to get a blood pressure cuff. LN 1 stated she was only going to be out of the room for 30 seconds. LN 1 then entered the room with the blood pressure cuff and closed the door behind her. On 2/19/15 at 8:00 A.M., LN 1 was interviewed at the medication cart. LN 1 acknowledged that she had been taught that medications were not to be left at the bedside under any circumstances. LN 1 stated she should have brought Resident 47's medications back to the medication cart and not left them at the bedside unattended. On 2/19/15 at 9:00 A.M., the Director of Nursing	F 425	**F 425** It is the intention of the facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. ***How corrective action will be accomplished for those residents found to have been affected by the deficient practice;*** On 02/19/15 DON conducted a 1:1 in-service to LN 1 for facility policy and procedure on Medication Administration. ***What Measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not occur;*** On 02/25/15 DON and Pharmacy Consultant conducted an in-service to all Licensed Nurses on facility policy and procedure on Medication Administration focusing on never leaving medications unattended. Pharmacy Nurse Consultant and DON will conduct a skills check on medication pass on all license nurses by 03/31/15. DON will continue to do a skills check on medication pass once a month on all License nurses for 6 months.	3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 425	Continued From page 13 (DON) was interviewed. The DON stated that LN 1 should not have left the medications at the bedside of Resident 47, unattended. The DON stated that the LNs were trained to follow the standard practice of keeping medications with them if they needed to go out and retrieve a forgotten item. The DON stated the nurses were trained to bring all needed items to the residents's room with the medications during medication administration.	F 425	***How the facility plans to monitor its performance to assure 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 and include dates when corrective action will be completed.*** Pharmacy consultant and DON will conduct a skills check on medication pass on all license nurses by 03/31/15. DON will continue to do a skills check on medication pass once a month on all License nurses for 6 months. DON will report findings and trends to the QA/CQI Committee for evaluation and further recommendation.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 431	Continued From page 14 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 document review, the facility failed to ensure for 2 non-sampled residents (Resident 24 and Resident 52) that: 1. Resident 24's medical record was accurately documented to track controlled substances (medications) used for Resident 24's pain. 2. A discharge medication for Resident 52 was properly labeled by the pharmacy in accordance with the state law, and consistent with the facility's policy and procedure. Findings: 1. During inspection of the discontinued controlled substances (CSs) kept in the locked cabinet, located in the Director of Nursing's (DON's) office, on 02/17/15 at 2:15 P.M. with the DON and the Director of Operations (DO), the following record for Resident 24 was reviewed and irregularities with documentation were identified: There was a physician's order for Norco 5/325 mg (narcotic pain medication), one tablet PRN (as needed) for moderate pain, and 2 tablets PRN for severe pain every 3 hours, which started on .	F 431	**F 431** It is the intention of the facility to have drugs and biologicals used must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. ***How corrective action will be accomplished for those residents found to have been affected by the deficient practice;*** DON and Pharmacist Nurse Consultant reviewed all residents PRN pain medication no other patients identified. On 02/17/15 DON and Pharmacist Consultant conducted an in-service to all Licensed Nurses for facility policy and procedure on Medication Administration. On 2/18/15 The Pharmacy Services Committee met, the following were present Administrator, Medical Director, Director of Operations, Director Of Nursing, AIT/Director of Staff Development. • Pharmacy Services Committee reviewed and revised facility policy and procedure on Disposition of Resident Drugs upon Discharge. o Revision Controlled substances shall not be released upon discharge of resident unless permitted by current state law	3/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 431	Continued From page 15 The documentation of the Controlled Drug Record for generic Norco 5/325 mg indicated, that a licensed nurse took 5 tablets on 1 tablet at 3 A.M., 2 tablets at 6 P.M., and 2 tablets at 5 P.M., from the bubble pack of Norco medication. Resident 24's PRN Pain Assessment flowsheet was reviewed. Resident 24's PRN Pain Assessment Flowsheet, failed to indicate staff documentation of the administration of PRN pain medication to Resident 24 on . Review of Resident 24's PRN Medication Administration Record (MAR) indicated staff documentation of 2 tablets of Norco were given to the resident for severe pain on , and 2 tablets for severe pain on During the review an interview with the DON was conducted in which the DON stated that, the documentation on the Controlled Drug Record for Norco for Resident 24, did not match the MAR. And that, the date entered on the Controlled Drug Record might not be accurate, and there were inconsistencies, and a lack of documentation on the MAR and PRN Pain Assessment Flowsheet. Review of the facility's policy and procedure titled: "Handling Discontinued Drugs," indicated: "Drugs which have been dispensed for individual resident use and are labeled in conformance with state and federal law for out-resident use shall be furnished to residents on discharge." Review of the facility's policy and procedure titled: "Medication Labeling & Proper Storage," indicated: "Each prescription drug on hand in the	F 431	governing the release of controlled substances and as authorized by the resident's attending physician. Drugs must be labeled in conformance with STATE and FEDERAL LAW for out-resident. ***What Measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not occur;*** Pharmacy Nurse Consultant and DON will conduct a skills check on medication pass on all license nurses by 03/31/15. DON will continue to do a skills check on medication pass once a month on all License nurses for 6 months. Medical Records will audit and review all PRN medication administration documentation. Findings and trends will be reported to DON. DON will review all residents discharge orders for disposition of resident medications for 1 month. ***How the facility plans to monitor its performance to assure 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 and include dates when corrective action will be completed.***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 431	Continued From page 16 facility must bear a pharmacist's prescription label and must be prescribed for a specific resident." Entered on the prescription label must be the following: "Initials of dispensing pharmacist." 2. During inspection of the discontinued controlled substances (CSs), kept in the locked cabinet located in the DON's office, on 2/17/15 at 2:15 P.M., with the DON (director of nurses) and DO (director of operations), the following record for Resident 52 was reviewed and irregularities with documentation were identified: There was a physician's order dated for Roxicodone (narcotic pain medication) 15 mg every 6 hours PRN (as needed) for pain related to lupus (a chronic inflammatory disease that occurs when your body's immune system attacks your own tissues and organs) and no more than 4 doses in 24 hours. There was another physician's order dated , to allow the resident to be discharged home with all of the resident's medications, and a 3 day supply of narcotic medication. Review of the resident's Controlled Drug Record form showed documentation indicating that, 36, 1/2 tablets of generic Roxicodone 10 mg, were punched out of the bubble pack. During a joint interview with the DO and observation of the bubble pack of Roxicodone, the DO stated that the doses were punched out of the Roxicodone bubble pack and placed inside a small plastic bag. The bubble pack indicated that 3, 1/2 tablets of generic Roxicodone 10 mg would make one dose of 15 mg, as ordered by the	F 431	Pharmacy consultant and DON will conduct a skills check on medication pass on all license nurses by 03/31/15. DON will continue to do a skills check on medication pass once a month on all License nurses for 6 months. DON will report findings and trends to the QA/CQI Committee for evaluation and further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESIDIO HEALTH CARE CENTER	8625 LAMAR STREET SPRING VALLEY, CA 91977

(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 431	Continued From page 17 physician. The DO stated that the plastic bag was labeled with the peel-off label for reordering, then the directions for the discharged resident were hand written on the label by the licensed nurse. The DO stated the facility did not notify and request the pharmacy for discharge controlled substance medications, with the proper amount of medications and proper labeling. During an interview conducted on 2/18/15 at 2:30 P.M., the Consultant Pharmacist (CP) stated that he was not aware that the facility was repacking and re-labeling the discharge controlled substance medications without contacting the pharmacy. Review of the facility's policy and procedure titled: "Medication Administration" indicated: "Each dose administered to a resident shall be properly recorded in the resident's medical record. Each dose of PRN (when needed) medication that is administered must be explained as to time, dose, reason given, and effectiveness of the dose." Review of the facility's policy and procedure titled, "Administration of Pain Medication" indicated: "Document the administration of PRN (when needed) pain medication on the Pain Flow Sheet."	F 431		