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

"AMENDED"

PRINTED: 01/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055331	A. BUILDING ______ B. WING ______	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN RAFAEL HEALTHCARE & WELLNESS CENTER, LP	1601 5TH AVENUE SAN RAFAEL, CA 94901

(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 Extended Re-Certification Survey from 11/2/15-11/10/15. Representing the California Department Of Public Health: Health Facilities Evaluator Nurses: # 25962 and 32961. The census on the day of entry, 11/2/15 was 46 with one bed hold. There were 16 sampled Residents. Three Entity Reported Events (# CA00458823, CA00458574 and 463926 were investigated on the survey. Entity Reported Event # 458574 had one deficiency cited- see F 323 An Immediate Jeopardy was Identified on 11/3/15 at 5:45 p.m., under 483.65 Infection Control. The Immediate Jeopardy was abated on 11/6/15 at 1251 p.m.	F 000	**F000** Preparation, submission 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 in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law. **F167** **Corrective Action/s:**	12/21/15
F 167 SS=E	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167	The Administrator will place survey results binder and its contents in the lobby by the consumer bulletin board and another copy in the dining room. A notice of the availability was posted on 11/3/15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Abby C. MA — TITLE: Administrator — (X6) DATE: revised 1/11/2016

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.

POC accepted with administrator Abby Ma on 1/12/16 at 9:50Am by HFEN 25962

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F 167	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure recent survey result, complaint investigations, and the plan of corrections or a notice of their availability were accessible to residents, families, and visitors. This failure had the potential to deny residents and their responsible parties the right to this information. Findings: During an initial tour observation on 11/2/15, at 11:30 a.m., there was no recent survey result, complaint investigation result, or the plan of correction information or a notice of their availability to the residents, families, and visitors. During a confidential group interview on 11/3/15, at 10:30 a.m., seven of eight residents stated they did not know about a survey binder. The residents stated they did not know that they were allowed to review the survey results. During a concurrent observation and interview on 11/3/15, at 4:30 p.m., in front of the nurse's station, there were no survey or complaint investigation results nor a notice of their availability. Administrative Staff E validated the observation and found a "Survey Binder" with other binders in a semi-transparent plastic holder mounted on the wall inside the nurse's station, which was not readily accessible for residents, families, or visitors.	F 167	**How to Identify Other Residents:** Residents are informed of the location of the survey binders during monthly Resident Counsel Meeting by the Activities Director on 12/18/15. **Systemic Changes:** Administrator will inspect for availability and accessibility weekly and review the contents of the Survey Binder at least on a quarterly basis for completeness and accessibility. **Monitoring:** This process will be monitored by Administrator during her routine rounds of the facility. Concerns identified will be discussed with the QA Committee for possible recommendations and resolution.	
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=D	Continued From page 2 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to keep a bathroom clean and in good repair for five residents in rooms 7 and 8 when the bathroom had broken floor base and cracks on the floor near the toilet. This failure had the potential for the residents to use an unsanitary bathroom and compromising resident's health and psychosocial well-being. Findings: During a concurrent observation and interview on 11/5/15, at 9:05 a.m., in the bathroom shared by residents in room 7 and 8, the floor base was broken and multiple cracks were near the toilet. The floor had yellowish brown spots. Administrative Staff F stated the broken floor base and the cracks collected dust and could not be cleaned thoroughly. Administrative Staff F stated he would repair the bathroom floor. The facility policy and procedure titled "Resident Rooms and Environment," revised 1/1/12, indicated "The Facility provides residents with a safe, clean, comfortable, and homelike environment...1. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order..."	F 253	**F253** **Corrective Action/s:** Room 7 and 8 bathroom has been repaired by the Environmental Director on 11/17/15. **How to Identify Other Residents:** No other repair or replacement was identified after inspecting the remaining bathrooms by the Environmental Director on 11/18/15. **Systemic Changes:** Environmental Supervisor will conduct monthly rounds. Any issues will be documented on the Maintenance Repair Log for repair and follow-up. **Monitoring:** This process will be monitored by the Administrator by reviewing the Maintenance Log for any possible patterns or trends on a quarterly basis. Trends identified by the Administrator will be shared and	11/18/15

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F 253	Continued From page 3 The facility policy and procedure titled "Maintenance Service," revised 1/1/12, indicated "The Maintenance Department maintains all areas of the building, ground, and equipment...B. Maintaining the building in good repair and free from hazards..."	F 253	discussed with the Quality Assurance Committee for possible suggestions and resolution.	
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. 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 interview and record review, the facility failed to develop a care plan for activities of daily living (ADLs) for one of 16 sampled residents (Resident 9). This failure resulted in staff providing ADLs care for Resident 9 without a care	F 279	**F279** **Corrective Action/s:** Resident 9's comprehensive care plan for Activities of Daily Living has been reviewed and initiated by the IDT member on 11/10/15. **How to Identify Other Residents:** All residents may be affected by this deficient practice. Activities of daily living care plans will be audited by Medical Records Director and or MDS nurse on 12/15/15. Any resident records found to be lacking ADL care plan will be developed by the MDS nurse. **Systemic Changes:** 1. An In-service was provided to all licensed nurse by Director of Nursing (DON) on 1/6/16 on how to initiate a care plan.	12/31/15

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Continued From page 4

plan and had the potential to deliver inappropriate care to Resident 9.

Findings:

Resident 9's admission record indicated Resident 9 was admitted to the facility on 9/4/15 with diagnoses including vascular dementia with behavioral disturbance, muscle weakness, unspecified abnormalities of gait and mobility, and wandering in disease classified elsewhere.

Resident 9's comprehensive admission assessment (include completion of the minimum data set, an assessment tool, and care area assessment and care planning) dated 9/11/15, under section G (assess resident's ADLs), indicated Resident 9 required setup assistance to one person assist for ADLs including transfer, dressing, eating, and personal hygiene.

During a review of Resident 9's clinical chart on 11/5/15, at 3:45 p.m., there was no care plan for ADLs in the clinical chart.

During a concurrent interview and record review on 11/10/15, at 9:30 a.m., Licensed Staff J reviewed Resident 9's clinical chart and stated there was no care plan for ADLs. Licensed Staff J also reviewed Resident 9's comprehensive admission assessment dated 9/11/15 and stated they should develop a care plan for Resident 9's ADLs.

The facility policy and procedure titled "Care Planning," revised 3/1/14, indicated "It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting

F 279

2. Plans of Care for Activities of Daily Living (ADL) will be initiated by a Licensed Nurse upon admission of new residents.
3. ADL care plan will be reviewed and updated by the IDT members quarterly, annually, with change of condition and as needed.
4. Medical Records Director will conduct an Admission Audit of newly admitted residents on the 14th day of admission with emphasis on completing appropriate care plan based on the needs of each resident.

Monitoring:

1. This process will be monitored monthly by the Administrator by obtaining a copy of the Admissions Audit and a copy will be provided to the MDS nurse and the DON for necessary corrections if applicable.

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F 279	Continued From page 5 health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being...A licensed Nurse and/or other Interdisciplinary Team (IDT) member will initiate a Care Plan for the resident following admission in accordance with the initial assessment of the resident's medical, nursing, mental, and psychosocial needs...The Care Plan will be completed within seven (7) days after completion of the RAI (resident assessment instrument), Comprehensive Admission Assessment, and periodically reviewed and revised by IDT..."	F 279	2. Trends and or patterns identified by the DON will be discussed during the Quarterly QA Meeting for further suggestions and resolution.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F280** **Corrective Action/s:** 1. Resident 1,2,5,6,7,12 and 14 have been scheduled for care conference meeting with the Interdisciplinary team (IDT) on 12/29/15. 2. Social Services Director (SSD) and/or Medical Records Director (MRD) will be responsible for inviting resident and or responsible party to attend.	1/8/16

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F 280	Continued From page 6	F 280		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure staff invited residents or responsible parties to the care conference/planning meeting (a team including resident or responsible party, physician, nursing staff, dietary staff, social worker, activity staff, etc. meet together to discuss and plan resident's treatment, medication, and care in the facility) for seven of 16 sampled residents (Resident 1, 2, 5, 6, 7, 12, and 14). This failure had the potential to deny residents or their responsible parties the right to participate in care planning and treatment or changes in care and treatment. This failure also had the potential to prevent residents from obtaining or maintaining their highest physical, mental, and psychosocial well-being.

Findings:

During a group confidential interview on 11/3/15, at 10:30 a.m., seven of eight residents stated the facility did not invite them for care conference meeting.

Resident 6's clinical chart contained 30 Interdisciplinary Team Conference Records from 4/22/15 to 10/27/15 and the Resident/Responsible Party section did not indicate resident or responsible party was notified and attended the 30 care conference meetings.

During an interview on 11/4/15, at 12:30 p.m., Resident 6 stated she was not invited to the care conferences meetings. Resident 6 stated she would like to attend the meetings because "It's about me here." Resident 6 stated she wanted to

How to Identify Other Residents:

1. All residents may be affected by this deficient practice. MRD and or SSD will audit all residents for care conference meeting and the invitation on 1/5/16.
2. Any residents and or responsible party that were not invited to the care conference meeting will be invited to attend. SSD will mail invitation letters on 1/7/16.
3. The minimum data set (MDS) Coordinator will maintain a calendar to track MDS schedule.
4. This calendar will be used as a reference by the IDT members for inviting residents and/or responsible party involving care conference meeting/s.

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F 280	Continued From page 7 know about her care, medications, and treatment and "It's important." Resident 2's clinical chart contained two Interdisciplinary Team Conference Records with one record undated and one record dated 4/13/15. The undated conference record did not indicate resident or responsible party was notified of the care conference meeting. During an interview on 11/4/15, at 11:55 a.m., Resident 2 stated the facility did not invite him to the care conference meeting. Resident 2 stated he would like to attend the meeting because he wanted to know about his care and treatment. Resident 2 stated he believed his family would like to attend the meeting too. Resident 7's clinical chart contained two Interdisciplinary Team Conference Records dated 4/10/15 and 6/16/15, which did not indicate resident or responsible party was notified of the care conference meetings. During an interview on 11/4/15, at 2:05 p.m., Resident 7's family who was the resident's responsible party stated she had not been invited to the care conference meetings. She stated she wanted to attend the care conference. Resident 5's admission record indicated Resident 5 was re-admitted to the facility on 7/9/15. There was no Interdisciplinary Team Conference Record in the clinical chart. Resident 14's admission record indicated Resident 7 was re-admitted to the facility on 8/2/15. There was no Interdisciplinary Team Conference Record in the clinical chart.	F 280	**Systemic Changes:** 1. The IDT members within 7 days of admission, quarterly, annually, change of condition and as needed schedule a care planning conference to discuss the following but not limited to resident (a) treatment, (b) medication and (c) plan of care. 2. SSD will notify and invite the resident or responsible party of the date and time of the care conference meeting by mail. If requested, SSD will conduct phone conference if responsible party is unable to attend. 3. Documentation of presence of the resident and or responsible party will be noted on the care planning conference record by the IDT members.	

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F 280	Continued From page 8 Resident 12's admission record indicated Resident 12 was admitted to the facility on 10/7/15. There was no Interdisciplinary Team Conference Record in the clinical chart. During an interview on 11/4/15, at 12:50 p.m., Administrative Staff B stated IDT (interdisciplinary team) care conference was also a care planning meeting. Administrative Staff B stated IDT care conference was completed for admission, quarterly, annually, and other specific issues including pressure ulcer, weight changes, and fall. Administrative Staff B stated Administrative Staff E was responsible for scheduling the care conference and inviting the resident or responsible party. During an interview on 11/4/15, at 2:50 p.m., Administrative Staff E stated for the admission care conference, she would notify the resident or responsible party by letter or typed reminder. Administrative Staff E stated she would notify the resident or responsible party verbally for the subsequent care conferences. Administrative Staff E stated she would document the resident notification and attendance in the Interdisciplinary Team Conference Record. Administrative Staff E also reviewed Resident 2, 5, 6, and 7's Interdisciplinary Team Conference Records. Administrative Staff E acknowledged that not all residents had quarterly care conference and the documentation did not indicate residents or responsible parties were invited to the care conference. Administrative Staff E stated they met with Resident 6 a lot but did not know why the documents had not been completed. Administrative Staff E stated the facility had been losing documents but did not know what had	F 280	**Monitoring:** This process will be monitored by completing the following: 1. Monthly the SSD will provide a copy of the care conference schedule to Director of Nursing (DON). 2. Medical Records will audit monthly for care conference meeting and care planning conference form completion. The audit results will be forwarded to the DON. 3. Any trends identified by the DON will be discussed during Quarterly Quality Assurance Committee meeting for further review and recommendations.	

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F 280	Continued From page 9 happened to the missing documents. Administrative Staff E further stated some documents were filed to the wrong chart. During an interview on 11/5/15 at 9:40 a.m., Resident 1 stated that she had never been to a care conference meeting or invited to one. Resident 1 stated no one explained to her the importance of things regarding her care such as nutritional needs for healing the pressure ulcers. Resident stated that no one was a "teacher to talk to me" about her medical treatment. Review of Resident 1 medical record indicated she had multiple sclerosis (disease of the central nervous system) with right sided hemiplegia (inability to move one side of the body) and a history of pressure sore on her buttock area. Annual MDS dated 8/20/15 indicated she was able to make decisions with care and had a BIMS (mental status cognition) score of 15 out of 15. Her psychiatric evaluation dated 8/27/15 indicated she was depressed because the treatment of her pressure sore required bed rest and her MS was progressing with reduced use of the left arm. Review of her Interdisciplinary team (IDT) care conference record dated 10/22/15 did not indicate if the resident was invited and it was not documented that the resident attended the conference. The conference was about her wound care and type of treatment provided. Other IDT conference meetings on 10/22/15, 915/15, 10/6/15, 9/29/15, 9/22/15, 9/8/15 and 9/1/15 did not include documentation of Resident 1's presence as the responsible party at the meetings. The facility policy and procedure titled "Care Planning," revised 3/1/14, indicated "The care plan will be completed within seven (7) days after	F 280		

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F 280	Continued From page 10 completion of the RAI (resident assessment instrument), Comprehensive Admission Assessment, and periodically reviewed and revised by IDT at the following interval: i. Onset of new problems; ii. Change of condition; iii. quarterly; iv. Annually...The IDT team may include the following individuals: A. The resident and/or his/her family or legal representative; B. The Attending Physicians...D. The Licensed Nurse who has responsibility for the resident...F. Social Service staff member responsible for the resident...J. The Director of Nursing...The Facility will invite the resident and/or his/her family or legal representative to care planning meetings and use its best efforts to schedule care planning meetings at times convenient for the resident, family, and/or legal representative..."	F 280		
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, interview, and record review, the facility failed to ensure a care plan specified supervision to prevent elopement for one of 16 sampled residents (Resident 9). This failure resulted in Resident 9 leaving the facility without assistance. This failure also had the potential to endanger the resident's health and	F 323	**F323** **Corrective Action/s:** Elopement care plan for Resident #9 was updated to include 15 minutes monitoring of resident on 11/11/15 by the Interdisciplinary Team (IDT) members. **How to Identify Other Residents:** Residents at risk for elopement were reassessed and care plans were generated if needed. 1. Upon admission, quarterly, annually with change of condition and as needed the resident will be assessed by the licensed nurse / MDS nurse for elopement risk with use of the elopement assessment. Plan of Care for residents considered to be at risk for elopement will	1/8/16

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(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 323	Continued From page 11 safety. Findings: Resident 9's admission record indicated Resident 9 was admitted to the facility on 9/4/15 with diagnoses including vascular dementia with behavioral disturbance, muscle weakness, unspecified abnormalities of gait and mobility, and wandering in disease classified elsewhere. Resident 9's comprehensive admission assessment (include completion of minimum data set, an assessment tool, and care area assessment and care planning) dated 9/11/15, indicated Resident 9's brief interview for mental status score was 4, which indicated Resident 9 had severe impairment of memory and thinking. Resident 9's elopement risk assessment, dated 9/4/15, indicated Resident 9 was at risk for elopement from the facility due to multiple problems including mental status, mobility status, history of wandering or elopement, and resident stated desire to go home and wandered aimlessly. The care plan for wandering/elopement, dated 9/4/15, indicated approaches including "Measures to provide safety: wander guard (a device attached to a resident that could trigger the alarm when exiting the facility)...Provide adequate physical and social environments that provide activities appropriate for the resident's cognitive functioning and interests, as well as opportunities for walking, exploring and social interaction..." The care plan did not specify supervision to prevent Resident 9 from elopement from the facility.	F 323	be reviewed by the IDT members. 2. The IDT will determine which safety features are necessary such as use of wander guard. The care plan will be reviewed and updated quarterly, annually, and change of condition by the IDT to include safety measures for the individual resident. **Systemic Changes:** 1. Environmental supervisor will check the wander guard system weekly for proper functioning. 2. An In-service was provided to all licensed nurse by Director of Nursing on 1/6/16 on how to develop and implement a care plan. 3. Upon admission, quarterly, annually with change of condition and as needed the	

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	055331	A. BUILDING ____ B. WING ____	11/10/2015

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Continued From page 12

The resident monitoring tool, dated 9/16/15, indicated monitoring time frame for Resident 9 was every 15 minutes to monitor and document Resident 9's location and activity. The monitoring tool documentation for Resident 9's location and activity from 7:15 a.m. to 12:15 p.m. and 11:15 p.m. to 11:30 p.m. were blank.

The nurse's note, dated 9/16/15, at 11:30 a.m., revealed Resident 9 left the facility unattended, last seen in dining area at 11:15 a.m. participating activity.

The facility investigation report, dated 9/18/15, indicated "At approximately 12:10 pm facility received call from the fire crew and reported that they have resident (Resident 9)..."

The interdisciplinary team (IDT) conference record, dated 9/16/15, indicated "plan of care was updated to monitor the resident's whereabouts frequently, continue wander guard and continue to attempt redirection of resident when he wants to go outdoors..."

The care plan for wandering/elopement, dated 9/4/15, indicated a new approach "Frequent monitoring of resident's whereabouts." The care plan did not specify monitoring time frame or supervision to prevent Resident 9 from further elopement from the facility.

During an interview on 11/9/15, at 9:40 a.m., Resident 9 stated he remembered that a couple months ago, he left the facility without telling the staff. Resident 9 stated he wanted to find a bus to go to a bank in another city. Resident 9 stated he did not tell the staff before he left the facility

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resident will be assessed by the licensed nurse / MDS nurse for elopement risk with use of the elopement assessment. Revision and update of the care plan will be done quarterly, annually, and change of condition as needed to include appropriate safety precautions for the individual resident.

4. Elopement binder will be updated upon assessment of wandering risk by the Director of Nursing and or nursing supervisor. It will include the following contents but not limited (a) picture and (b) Face sheet of residents at risk for wandering.

Monitoring:

This process will be monitored by completing the following:

1. DON and or MDS nurse will maintain a list of residents

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F 323	Continued From page 13 because he was responsible for his own stuff. Resident 9 stated he was aware of the alarm sound when he walked through the front door and stated "I guess it's for safety." Resident 9 state he did not know he had a device that triggered the alarm. During an interview on 11/9/15, at 11:50 a.m., Administrative Staff D stated she saw Resident 9 on 9/16/15 during activity program duration from 10:30 a.m. to 11:30 a.m. Administrative Staff D stated Resident 9 left the activity at approximately 11 a.m. Administrative Staff D stated at approximately 11:30 a.m. all staff was looking for the resident so she knew Resident 9 was missing. Administrative Staff D stated she knew Resident 9 would go outside for smoking but did not know the resident was at risk for elopement. During an interview on 11/9/15, at 1:35 p.m., Unlicensed Staff T stated she was assigned to Resident 9 on 9/16/15. Unlicensed Staff T stated she knew Resident 9 was on every 15 minutes check because Resident 9 tried to leave the facility. Unlicensed Staff T stated sometimes she could not check on Resident 9 every 15 minutes when she had to take care of another resident. Unlicensed Staff T stated she would tell the nurse or staff in the front when she was not able to watch the resident. Unlicensed Staff T stated all staff should be responsible checking on Resident 9. Unlicensed Staff T stated on 9/16/15, at approximately 10:30 a.m., she assisted Resident 9 to the dining room for coffee and left the resident. Unlicensed Staff T stated she was taking care of another resident and knew Resident 9 was missing near lunch time. Unlicensed Staff T stated Resident 9 had a wander guard and should trigger the alarm but	F 323	at risk for elopement and see to it that a corresponding care plan is specific for each resident's needs. 2. Trends identified by the DON based on the results of the quarterly audits will be shared with Quality Assurance Committee at least on a quarterly and as needed basis for further suggestions.	

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F 323	Continued From page 14 did not know why Resident 9 was still able to "escape." During an observation on 11/5/15, at 4:25 p.m., Resident 9 walked out of the facility with a cane from the front door and the alarm sounded. Licensed Staff L looked outside the door and then went to the nurse station. Administrative Staff A re-set the alarm. Resident 9 was sitting in front of the facility inside the gate. At 4:47 p.m., Resident 9 was sitting alone in the neighbor's front yard. Resident 9 walked back to the facility at 4:52 p.m. and the alarm sounded. Licensed Staff L re-set the alarm. Licensed Staff L had been working inside the nurse station while Resident 9 was outside the facility. During an interview on 11/5/15, at 5 p.m., Licensed Staff L stated Resident 9 was at risk for elopement and had dementia. Licensed Staff L stated Resident 9 had a wander guard. When asked about Resident 9 going out the facility and triggered the alarm but no staff going out with the resident, Licensed Staff L stated Resident 9 was happy where he was now. Licensed Staff L stated they wanted to keep the wander guard for the resident so "we know he is outside." Licensed Staff L stated they could see the resident from the window in the nurse station. When asked how staff could see Resident 9 when he was off the facility in the neighbor's front yard, Licensed Staff L stated "We may need to take off his wander guard." During an interview on 11/5/15, at 5:10 p.m., Licensed Staff K stated Resident 9 should not go out of the facility by himself because Resident 9 was elopement risk. Licensed Staff K stated a staff had to go out with Resident 9. Licensed	F 323		

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Staff K stated Resident 9 was on every 15 minutes check and any CNA (certified nursing assistant) could check on Resident 9.

During an interview on 11/5/15, at 5:45 p.m., Unlicensed Staff S stated he was assigned to Resident 9. Unlicensed Staff S stated he had other residents, so he could not check on Resident 9 every 15 minutes. Unlicensed Staff S stated Resident 9 went out the facility at 4:25 p.m. Unlicensed Staff S stated Resident 9 had a wander guard and should have alerted the other staff.

During an interview on 11/9/15, at 4:20 p.m., Administrative Staff B stated the care plan for wander/elopement and the IDT notes did not include every 15 minutes check for Resident 9 while monitoring tool indicating every 15 minutes check. Administrative Staff B stated the intervention "frequent monitoring..." was initiated on 9/16/15. When asked what did "Frequent monitoring" mean, Administrative Staff B stated she did not specify how frequently monitor the resident. When asked about the blank documentation for 9/16/15 from 7:15 a.m. to 12:15 p.m., Administrative Staff B stated the every 15 minutes check was just extra work for the staff but was not mandatory for staff.

The facility policy and procedure titled "Wandering & Elopement," revised 12/1/12, indicated "Facility Staff will reinforce proper procedures for leaving the Facility for residents assessed to be at risk of elopement...If Facility Staff observes a resident leaving the premises without having followed proper procedures, he/she may: A. Try to prevent the departure in a courteous manner; B. Get help from other Facility

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F 323	Continued From page 16 Staff in the immediate vicinity..."	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the medication pass was error free when the facility had a medication error rate of 9.3 % which could decrease the health and safety of residents due to improper administration of medications. Findings: During observations of 43 medication passes from 11/2/15 through 11/4/15, there were 4 medication administration errors. These errors occurred when: 1. Insulin (medication to prevent high blood sugar) was administered to one resident, (Resident 11) out of 6 insulin dependent sampled residents, with the needle cap on, failing to ensure the patient received insulin. 2. Two Staff member failed to administer insulin to three resident (Resident 13, 4 and 5) out of 6 insulin dependent sampled residents according to physician orders or manufacturer's recommendations for timing with meals. 1. During an observation on 11/3/15 at 6:05 a.m.,	F 332	**F332** **Corrective Action/s:** 1. Resident 11 was given his dose of insulin on 11/3/15 by a licensed nurse. Resident was discharged on 11/10/15. 2. Residents 4, 5, 11 and 13 were monitored on 11/3/15 for signs and symptoms of hypoglycemia by the licensed nurses. No signs or symptoms of hypoglycemia were noted related to not following manufacturer's recommendation for timing with meals. **How to Identify Other Residents:** All diabetic residents receiving insulin on 11/3/15 were re-assessed by a licensed nurse for signs and symptoms of hypoglycemia. No other residents were found to have signs or symptoms of hypoglycemia.	1/8/16

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F 332	Continued From page 17 Licensed Staff H administered 18 units of Lantus (long acting insulin) using an insulin pen to Resident 11. The pen needle had a white cap. Licensed Staff H put the pen up next to Resident 11's right upper arm and pressed the plunger. Licensed Staff H then came out of the room to the medication cart and stated he forgot to take the plastic cap off, "I found my own mistake" and stated he would go in and re-inject the resident with the insulin. Licensed Staff H then went back in Resident 11's room after removing the white cap on the insulin pen. There was still a blue covering over the needle and Licensed Staff H placed the pen up to the the right upper arm of Resident 11 and pressed the plunger of the pen, fluid ran down the residents arm as Licensed Staff H attempted to inject the insulin. Licensed Staff H returned to the medication cart with the blue covering over the needle. When asked if he saw that, there was a cover over the needle, Licensed Staff H stated that he did not realize there was a cover over the needle and would have to give the insulin. Licensed Staff H stated that the insulin pen was a new device to him. 2. During an observation on 11/3/15 at 6:20 a.m., Licensed Staff H gave Resident 13 two units of Regular Humulin insulin and stated Resident 13's breakfast came at 7:30 a.m. During an observation on 11/3/15 at 7:30 a.m., staff began feeding Resident 13 his breakfast which was one hour and 10 minutes after Resident 13 received his insulin. Review of the facility's "Insulin Onset/ Peak/ Duration of Action" undated information sheet, located in the front of the Medication binder, indicated Regular Humulin insulin began working	F 332	**Systemic Changes:** 1. An In-service was provided to all licensed nurses by Director of Nursing (DON) on 11/17/15 on types of insulin including onset peak and duration of insulin and meal timing. 2. An in-service was provided to all licensed nurses by pharmacist and or DON on use of the insulin pen on 12/18/15. 3. During orientation and annually, licensed nurses will be in-serviced by the Director of Staff Development (DSD) and or DON on different types of insulin and following guidelines for insulin administration and proper timing of meals. 4. The DSD and or DON to complete competency for administration of insulin using the insulin pen with	

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F 332	Continued From page 18 in 30 minutes. Review of the manufacturer's physician information on Humulin Regular insulin 100 units per ml, dated 2015, indicated the insulin should be followed by a meal within approximately 30 minutes of administration. During an observation on 11/3/15 at 11:35 a.m., Licensed Staff K administered 2 units of Novolog insulin to Resident 5 and stated it was quick acting, that it worked in 30 minutes. During an observation on 11/3/15 at 12:05 p.m., Resident 5 was pushed into the dinning room in her wheelchair and brought to a table. Resident 5's food was not brought to her table until 12:20 p.m., which was 40 minutes after the insulin was injected. Review of Resident 5's medical record admission face sheet indicated she had a history of chronic kidney disease and hypertension and November physician orders indicated she had Type Two Diabetes and received Novolog 100 units/ml SQ TID (subcutaneous injection three times a day) before meals. Review of the facility's "Insulin Onset/ Peak/ Duration of Action" undated information sheet located in the front of the Medication binder, indicated Novolog insulin was fast acting and starts working within 15 minutes. Review of the facility's manufacturer's information for Novolog insulin, indicated Novolog had a rapid onset of action and that an injection of Novolog should be immediately followed by a meal within 5 to 10 minutes.	F 332	licensed nurses during orientation and annually. **Monitoring:** This process will be monitored by completing the following: 1. The DON or DSD and or the Pharmacist on a monthly basis will observe licensed nurses during med pass for proper insulin administration and use of insulin pens. Training will be provided as deemed appropriate with licensed nurses by the DON and or DSD. 2. Results of monthly monitoring of med pass observation will be forwarded to the Quarterly Quality Assurance committee by the DON or DSD for further review and recommendations.	

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F 332	Continued From page 19 During an observation on 11/3/15 at 6:55 a.m., Licensed Staff H administered 4 units of Humalog to Resident 4 and stated that the breakfast came between 7 and 7:30 p.m. Licensed Staff H stated that he was not sure if Humalog was long or short acting. Licensed Staff H stated that he knew Regular insulin peaked in 30 minutes and Novolog may be long acting where it peaked in 12 to 14 hours. Licensed Staff H stated Resident 4 got his insulin three times a day before meals. During an observation on 11/3/15 at 7:25 a.m., Resident 4 received his meal which was 30 minutes after the administration of Humalog. Review of Resident 4's medical record admission face sheet indicated Resident 4 had a history of hypertension and 11/15 physician orders indicated he had Type 2 diabetes and should receive Humalog 100 units/ml SQ TID (subcutaneous injection three times a day) with meals. Review of the facility's "Insulin Onset/ Peak/ Duration of Action" undated information sheet located in the front of the medication binder, indicated Humalog insulin was fast acting and starts working within 15 minutes. Review of the facility's manufacturer's information for Humalog insulin indicated Humalog U-100 should be administered within 15 minutes before a meal or immediately after a meal by injection in the subcutaneous tissue. During an interview on 11/5/15 at 12:20 p.m., Administrative Staff B stated that there was no specific policy and procedure for insulin	F 332		

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F 332	Continued From page 20 administration. Review of Medication -Administration policy, dated 1/1/12 indicated medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The policy indicated nurses should keep in mind the seven rights of medication administration including the right amount and the right time of medication administration.	F 332	**F333** **Corrective Action/s:** 1. Resident 11 was given his dose of insulin on 11/3/15 by licensed nurse. Resident was discharged on 11/10/15. 2. Residents 4, 5, 11, and 13 were monitored on 11/3/15 for signs and symptoms of hypoglycemia. No signs or symptoms of hypoglycemia were noted related to not following manufacturer's recommendation for timing with meals. **How to Identify Other Residents:** All diabetic residents receiving insulin on 11/3/15 were re-assessed by a licensed nurse for signs and symptoms of hypoglycemia. No residents found to have signs or symptoms of hypoglycemia.	1/8/16
F 333 SS=F	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of medical orders, policy and manufacturers guidelines, the facility failed to ensure: 1. Insulin was administered as prescribed when one staff member attempted to administer insulin to one resident (Resident 11) out of six insulin dependent residents with the needle cap on, failing to ensure the patient received insulin (medication to prevent high blood sugars) which could have resulted in high blood sugars. 2. Two Staff members failed to administer insulin to three of six residents according to physician orders or according to the manufacturer's recommendations potentially leading to low blood sugar when meals were not served in required time frames.	F 333		

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Findings:

1. During an observation on 11/3/15 at 6:05 a.m., Licensed Staff H prepared to inject Resident 11 with 18 units of Lantus (long acting insulin) using an insulin pen (disposable prefilled syringe). The pen had a white cap. Licensed Staff H put the pen next to Resident 11's right upper arm and pressed the plunger. Licensed Staff H then came out of the room to the medication cart and stated he forgot to take the plastic cap off, "I found my own mistake" and stated he would go in and re-inject the resident with the insulin. Licensed Staff H went back in Resident 11's room after removing the white cap on the insulin pen. There was still a blue covering over the needle and Licensed Staff H placed the pen with the blue covering over the needle up against the right upper arm of Resident 11 and pressed the plunger, fluid ran down the resident's arm as Licensed Staff H attempted to inject the insulin. Licensed Staff H walked out to the medication cart with the blue covering over the needle. When asked if he saw there was a cover over the needle, Licensed Staff H stated that he did not realize there was a cover over the needle and would have to inject the resident again. Licensed Staff H stated that the insulin pen was a new device to him.

On 11/10/15, review of the manufacturer's information on the Lantus Solostar disposable prefilled syringe, provided by the facility indicated that the pen cap with the needle had an outer needle cap and an inner needle cover over the needle. The instructions indicated that those who use the insulin pen must be knowledgeable how to use the pen to ensure an accurate dose as too little or too much insulin can affect blood sugar

Systemic Changes:

1. An In-service was provided to all licensed nurses by Director of Nursing (DON) on 11/17/15 on types of insulin including onset peak and duration of insulin and meal timing.

2. An in-service was provided to all licensed nurses by pharmacist and or DON on use of the insulin pen on 12/18/15.

3. During orientation and annually, licensed nurses will be in-serviced by the Director of Staff Development (DSD) and or DON on different types of insulin and following guidelines for insulin administration and proper timing of meals.

4. The DSD and or DON to complete competency for administration of insulin using the insulin pen with

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F 333	Continued From page 22 levels. During an interview on 11/9/15 at 4:20 p.m., while reviewing Licensed Staff H's personal file, Administrative Staff C stated that the licensed Staff's individual unit had their specific competencies such as medication pass, completed by the nursing unit supervisors. During an interview on 11/10/15 at 3:20 p.m., Administrative Staff B who was the Director of Nurses stated she could not find any unit specific medication administration or insulin injection competencies for Licensed Staff H in the staff's training files. 2. During an observation on 11/3/15 at 6:20 a.m., Licensed Staff H gave Resident 13 two units of Regular Humulin insulin and stated Resident 13's breakfast came at 7:30 a.m. During an observation on 11/3/15 at 7:30 a.m., staff began feeding Resident 13 his breakfast which was one hour and ten minutes after Resident 13 received insulin. Review of Resident 13's medical record admission face sheet indicated Resident 13 was a type two diabetic (inability of the body to produce enough insulin to keep sugar in the blood from becoming too high). Physician orders dated 11/2015 for Resident 13, indicated Resident 13 received Regular Humulin insulin 100 u/ml per SS QAC and HS (sliding scale or per blood sugar reading before meals and at bedtime). Review of the facility's "Insulin Onset/ Peak/ Duration of Action" undated information sheet	F 333	licensed nurses during orientation and annually. **Monitoring:** This process will be completed by completing the following: 1. The DON or DSD and or the Pharmacist on a monthly basis will observe licensed nurses during med pass for proper insulin administration and use of insulin pens. Training will be provided as deemed appropriate with licensed nurses by the DON and or her designee. 2. Results of monthly monitoring of med pass observation will be forwarded to the Quarterly Quality Assurance committee by the DON or designee for further review and recommendations.	

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F 333	Continued From page 23 located in the front of the Medication binder, indicated Regular Humulin insulin began working in 30 minutes. Review of the manufacturer's physician information on Humulin Regular insulin 100 units per ml, dated 2015, indicated the insulin should be followed by a meal within approximately 30 minutes of administration. During an observation on 11/3/15 at 11:35 a.m., Licensed Staff K administered 2 units of Novolog to Resident 5 and stated it was quick acting, and worked in 30 minutes. During an observation on 11/3/15 at 12:05 p.m., Resident 5 was wheeled into the dinning room. Resident 5's food was not brought to her table until12:20 p.m., which was 45 minutes after the insulin was administered. Review of Resident 5's medical record admission face sheet indicated Resident 5 had a history of chronic kidney disease and hypertension and 11/15 physician orders indicated Resident 5 had Type Two Diabetes and received Novolog 100 units/ml SQ TID (subcutaneous injection three times a day) before meals. Review of the facility's "Insulin Onset/ Peak/ Duration of Action" undated information sheet, located in the front of the Medication binder, indicated Novolog insulin was fast acting and started working within 15 minutes. Review of the facility's manufacturer's information for Novolog insulin indicated Novolog had a rapid onset of action and that an injection of Novolog should be immediately followed by a meal within	F 333		

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F 333	Continued From page 24 5 to 10 minutes. During an observation on 11/3/15 at 6:55 a.m., Licensed Staff H administered 4 units of Humalog to Resident 4 and stated that the breakfast came between 7 and 7:30 p.m. Licensed Staff H stated that he was not sure if Humalog was long or short acting. Licensed Staff H stated that he knew regular insulin peaked in 30 minutes and Novolog may be long acting where it peaked in 12 to 14 hours. During an observation on 11/3/15 at 7:25 a.m., Resident 4 received his meal which was 30 minutes after the administration of Humalog. Review of Resident 4's medical record admission face sheet indicated Resident 4 had a history of hypertension and physician's orders dated 11/2015, indicated he had Type 2 diabetes and received Humalog 100 units/ml SQ TID (subcutaneous injection three times a day) with meals. Review of the facility's "Insulin Onset/ Peak/ Duration of Action" undated information sheet located in the front of the Medication binder on the medication cart, indicated Humalog insulin was fast acting and started working within 15 minutes. Review of the facility's manufacturer's information for Humalog insulin indicated Humalog U-100 should be administered within 15 minutes before a meal or immediately after a meal by injection in the subcutaneous tissue. During an interview on 11/5/15 at 12:20 p.m., Administrative Staff B stated that there was no	F 333		

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F 333	Continued From page 25 specific policy and procedure for insulin administration. Review of Medication -Administration policy, dated 1/1/12 indicated medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The policy indicated nurses should keep in mind the seven rights of medication administration including the right amount and the right time of medication administration.	F 333	**F361** **Corrective Action/s:** Full-time Dietary Supervisor is in place. Registered Dietitian (RD) visits weekly.	11/30/15
F 361 SS=D	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a full-time dietitian or a full time dietary supervisor. This failure resulted in insufficient supervision of the dietary staff to ensure proper dietary infection control practices.	F 361	**How to Identify Other Residents:** 1. Dietary Supervisor will supervise the dietary staff by observation of staff for food safety and proper dietary infection control practices in the kitchen. Dietary Supervisor will provide training to staff during orientation, annually and as needed. 2. Dietary Supervisor will review and audit weekly the food temperature logs, thermometer calibration log, and cleaning schedule for completion.	

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F 361	Continued From page 26 (Cross Reference F 371) Findings: During a concurrent observation and interview on 11/2/15, at 4:30 p.m., Administrative Staff G stated they did not have a full time dietary supervisor now. Administrative Staff G stated she was a new hire for part time and came in the evening for a few hours to order foods. Administrative Staff G further stated the dietary supervisor should be a full-time position. During the same observation and interview on 11/2/15, at 4:30 p.m., the RD (registered dietitian) stated she work for the facility as a consultant. The RD stated the dietary supervisor was out on leave for six to eight weeks. The RD stated she came to the facility one to two days a week and eight to nine hours per day while the dietary supervisor was out on leave. During a concurrent interview and record review of the personnel file and employee time cards, Administrative Staff U stated Administrative Staff G was hired on 10/15/15 for an on-call position. Administrative Staff U stated the RDs were contracted consultant and were not full time. Administrative Staff U stated the dietary supervisor was out on leave since 10/2/15. During an interview on 11/10/15, at 12:25 p.m., Administrative Staff A stated the dietary supervisor was out on leave since 10/2/15 and they hired an on-call dietary supervisor. Administrative Staff A stated they will hire a temporary full-time dietary supervisor if the dietary supervisor would not return soon.	F 361	3. RD will observe the dietary staff for infection control practices monthly. **Systemic Changes:** Dietitian consultant reports will be reviewed by Dietary Supervisor and Administrator for follow-up. **Monitoring:** 1. Administrator and or RD consultant will monitor for full-time dietary supervisor in the facility. 2. Administrator will ensure dietary supervisor's presence during daily rounds. 3. Dietary Supervisor will inform Administrator of any absence. 4. Trends identified on the RD consultant reports will be reported by the Administrator to the Quarterly Quality Assurance Committee for further review and recommendations.	

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F 371	Continued From page 27	F 371		
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 ensure food was served under sanitary conditions when: 1. expired food items were found in the kitchen refrigerator, food storage shelf, dry storage area, and emergency food storage area; 2. some bananas with black spots and open skin were stored in the kitchen; 3. food temperature logs, kitchen cleaning logs, thermometer calibration logs were incomplete; and 4. the binders containing documents in the kitchen had thick black sticky substance. These failures had the potential to cause cross-contamination and food-borne illness to the residents who received their food from the kitchen. Findings: 1. During an observation on 11/2/15, at 10:10 a.m., in the kitchen, some bagels in two plastic bags with written dates 10/23/15 and 10/24/15 were on the shelf in front of the refrigerators. Dietary Staff A validated the observation and	F 371	**F371** **Corrective Action/s:** Expired red peppers, dry beans, stuffing, thickened apple juice, and bananas were removed and thrown out. The binders were replaced on 11/6/15. **How to Identify Other Residents:** All residents have the potential to be affected by this deficient practice. Director of Nursing reviews 24 hour report for changes of condition. No residents were found to be affected with this deficient practice (i.e. food-borne illness). 1. Registered Dietitian provided in-service to dietary staff on food labeling and dating and storage guidelines on 11/19/15. 2. RD and dietary supervisor inspected food storage areas for expired food items, no other items were identified on 11/5/15.	1/7/16

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F 371	Continued From page 28 stated the written dates might be the open dates. Dietary Staff A stated there were no expiration dates on the bags. Also, a box of red peppers with an open date 10/20/15 was stored in refrigerator #3. There was no expiration date on the box. During an observation on 11/2/15, at 10:33 a.m., in the dry food storage area, five bags of dry beans dated May 29, 2014 and three bags of chicken flavor stuffing dated 6/3/2014 were stored in the food storage shelf. Dietary Staff A validated the observation and stated the dates on the bags should be the dates the facility received the products. During a concurrent observation and interview on 11/4/15, at 4:30 p.m., in the emergency food storage area, six boxes of 46 oz. (ounce) thickened apple juice with a use by date 4/9/15 and six boxes of 46 oz. thickened apple juice with a use by date 7/7/15 were stored in the shelf. Administrative Staff G stated the use by date was the expiration date, so the thickened apple juice was expired. Administrative Staff G removed the thickened apple juice from the storage area. The facility's policy and procedure titled "STORAGE OF FOOD AND SUPPLIES," undated, indicated "All food products will be used per the times specified in the 'Dry Food Storage Guidelines'...No food will be kept longer than the expiration date on the product..." The "DRY GOODS STORAGE GUIDELINES," dated 8/15, indicated unopened dry beans on shelf storage time was one year. The opened and unopened bread storage time was 5-7 days. The opened and unopened bread crumbs storage	F 371	3. RD in-serviced dietary staff on the food temperature logs, cleaning schedule, and thermometer calibration logs on 11/6/15. 4. RD and or dietary supervisor in-serviced dietary staff on food safety on 1/7/16. **Systemic Changes:** 1. Dietary Supervisor will check weekly for expired food. 2. Dietary Supervisor will review and audit weekly the food temperature logs, thermometer calibration log, and cleaning schedule for completion. 3. RD will observe monthly the dietary staff for sanitation and food safety practices.	

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F 371	Continued From page 29 time was 6 months. During an interview on 11/4/15, at 5:30 p.m., Administrative Staff G stated chicken flavor stuffing storage time was the same as the bread crumbs storage time. The "PRODUCE STORAGE GUIDELINES," dated 8/15, indicated to store green or red peppers in the refrigerator for 7 to 10 days. 2. During an observation on 11/2/15, at 10:10 a.m., in the kitchen, some bananas with black spots and open skin were stored in the shelf in front of the refrigerators. Dietary Staff A validated the observation. During a concurrent observation and interview on 11/2/15, at 4:30 p.m., some bananas with black spots and open skins were stored in the food storage shelf in the kitchen. Administrative Staff G stated the bananas with some black spots and intact skin could be served to residents. Administrative Staff G stated the dietary supervisor should visit the kitchen every day and throw away things that were not good. Administrative Staff G stated they did not have a full time dietary supervisor now. Administrative Staff G stated she was a new hire for part time and came in the evening for a few hours to order foods. The facility's policy and procedure titled "STORING PRODUCT," dated 3/13, indicated "Bananas should be stored at room temperature. When fully ripe, bananas may be stored in the refrigerator for five days, as long as they have no open skins. If bananas are stored in the refrigerator, the peel will turn black, so they	F 371	**Monitoring:** Trends identified by the Administrator or RD Consultant will be reported by the Dietary Supervisor to the quarterly Quality Assurance Committee for further review and recommendations.	

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F 371	Continued From page 30 should only be served at this point if peeled or used for banana bread." 3. During a concurrent interview and record review on 11/6/15, at 9:40 a.m., food temperature logs from August 2015 to November 2015 were incomplete. The RD stated if the temperature of the food was not monitored, improper food temperature could cause food borne illness. During a concurrent interview and record review on 11/6/15, at 9:40 a.m., the kitchen cleaning schedule and check list binder contained one page of cleaning schedule with an unclear date and incomplete log. The RD stated she did not find any cleaning log for 2015. The RD stated she did not post the cleaning log for November 2015 and will post the log as soon as possible. The RD stated the kitchen staff knew the cleaning but just did not have the log to document the cleaning. During a concurrent interview and record review on 11/6/15, at 9:40 a.m., the "WEEKLY THERMOMETER CALIBRATION CHART" revealed the interval for the thermometer calibration was not consistent and varied from every day up to not done for 23 days (i.e. from 5/12/15 to 6/4/15, 23 days). The calibration chart indicated "All thermometers should be calibrated at least once a week..." The RD stated she interpreted weekly as any day in every week and not necessary every 7 days. The RD stated if the thermometer was not calibrated, it had the potential for incorrect temperature of food and cause food borne illness. 4. During a concurrent interview and record review on 11/6/15, at 9:40 a.m., the binders for	F 371		

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F 371	Continued From page 31 food temperature logs, kitchen cleaning logs, thermometer calibration logs had thick black sticky substance. The RD stated she will change the binders. The facility's policy and procedure titled "SANITATION," undated, indicated "...The Dietary Supervisor will write the cleaning schedule in which he designates by job tilted and/or employee who is to do the cleaning task...All utensils, counters, shelves and equipment shall be kept clean...The kitchen staff is responsible for all the cleaning with the exception of ceiling vents...Correct temperatures for the storage and handling of foods are used. Thermometers will be used to check temperatures of refrigerators, freezers and in food storeroom. Thermometers will also be used to check the food at meal times..."	F 371		
F 441 SS=K	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.	F 441	**F441** **Corrective Action/s:** 1. MD and residents 4, 5, 11, 13, and 14 were notified on 11/3/15 of potential for blood borne infection secondary to not disinfecting the glucometer. 2. A new glucometer was provided immediately on 11/3/15 and residents were monitored for 72 hours for signs and symptoms of blood borne infection. All licensed nursing staff was in-serviced on 11/3/15 for the procedure to disinfect the glucometer using the recommended wait time.	1/8/16

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F 441	Continued From page 32 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy and manufacturers information, the facility failed to ensure infection control procedures were followed when: 1. One staff member, Staff H cleaned glucometers (blood sugar testing device) between five out of 14 sampled residents (4, 5, 11, 13,14). This resulted in the potential for transfer of blood borne organisms and infection between residents through cross contamination. Due to the failure for the facility to clean the glucometer between the use of five residents, an immediate jeopardy was identified on 11/3/15 at 5:45 p.m. The Administrator, Director of Nurses	F 441	3. No residents were directly affected by Housekeeping insufficient education on contact cleaning time of disinfectant solutions. However there is potential for residents to be exposed to contaminated surfaces related to deficient practice. 4. Sterile containers improperly stored under a sink were removed on 11/3/15 and relocated to central supply. Small supplies of containers are located in upper self of the medication room away from possible contamination. 5. A sign will be posted on medication carts indicating for visitors to ask for assistance prior to obtaining water/supplies from medication cart. Director of Staff Development (DSD) In-serviced nursing staff on 12/21/15 to assist residents and victors to obtain water	

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F 441	Continued From page 33 and the Nurse Quality Consultant were informed that License Staff H did not clean the glucometer between sampled residents (4,5,11,13,14). Immediate Jeopardy was abated on 11/6/15 at 12:51 p.m., when all licensed nurses were in-serviced begining 11/3/15 on glucometer disinfection between resident usage with focus on the contact time of the disinfectant per manufacture's instructions. The Administrator, Director of Nurses and the Nurse Quality Consultant were present. 2. One out of two housekeeping staff (Q) were not aware of the contact cleaning time for a disinfectant cleaner used to clean resident's room. This could result in the spread of infection to another resident. 3. License Staff H and K were not washed their hands after the removal of gloves which could lead to cross contamination and illness among facility residents. 4. Sterile urine culture cups were stored out of the way of possible water droplet or spray contact. 5. One family member obtained water from a container on the medication cart after assisting a resident to eat and without washing her hands, which could lead to cross contamination of bacteria between residents. Findings: During an observation on 11/3/15 at 5:55 a.m., Licensed Staff H pulled a blood testing meter device (glucometer) out of the medication cart. Licensed Staff H did not clean the meter and	F 441	or supplies from medication cart. **How to Identify Other Residents:** Diabetic residents were monitored on 11/3/15 by licensed nurse for next72 hours for signs and symptoms of blood borne infection. No other residents were noted to have any signs or symptoms of infection; no fever or lethargy. **Systemic Changes:** 1. All licensed staff was in-serviced on 11/03/15 by DON and or DSD on procedure to disinfect the glucometer between residents. The approved disinfectant was utilized and contact time was stressed. Return demonstration by nurses was done. 2. Newly hired licensed nurses during the orientation process and annually will receive education by DSD on	

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F 441	Continued From page 34 placed it on Resident 11's bedside table. There was a small blood strip inserted in the meter from which Licensed Staff H touched to Resident 11's finger, for completing the blood sugar test. After finishing, Licensed Staff H brought the meter back to the medication cart, discarded the strip in the trash and set the meter back on the medication cart without cleaning or disinfecting it. During an observation on 11/3/15 at 6:15 a.m., Licensed Staff H took the meter which had not been cleaned or sanitized into Resident 13's room and placed it on the bedside table with a new meter strip inserted. Licensed Staff H pricked Resident 13's finger with a lancet (sharp pointed surgical instrument used to make a small incision)and handled the meter with gloves and brought Resident 13's bleeding finger up to touch the strip in the meter. Licensed Staff H then brought the meter back to the medication cart and placed it on the cart without cleaning it. During an observation on 11/3/15 at 6:21 a.m., Licensed Staff H took the glucometer which had not been sanitized into Resident 14's room and placed it on her bedside table. Licensed Staff H then used the glucometer with a new strip inserted to touch her finger which had been lanced to withdraw blood. Licensed Staff H then returned to the medication cart and discarded the strip in the trash before putting the glucometer back on the medication cart. Licensed Staff H did not clean the glucometer or disinfect the glucometer after use. During an observation on 11/3/15 at 6:40 a.m., Licensed Staff H took the glucometer from the medication cart and placed it on Resident 5's bedside table. Licensed Staff H used the lancet	F 441	disinfection of glucometer. Training will include approved disinfectant and contact time. Return demonstration will be done. 3. The housekeeping district manager on 11/10/15 in-serviced the housekeeping staff on disinfectant solutions and time frame required to have efficient disinfection. 4. Housekeeping Supervisor and/or DSD will educate and train housekeeping staff upon hire, as needed and annually with regard to time frame for disinfectant solution and proper concentration for effective disinfection. 5. On 11-12-15 the DSD in-serviced nursing staff on universal precautions, handwashing and when removing gloves to wash their hands or use hands	

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	055331	A. BUILDING ______ B. WING ______	11/10/2015

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F 441	Continued From page 35 device to prick her finger and squeezed her finger as he brought the glucometer with the meter strip up to the finger to touch the blood on the finger. He then took the meter back out to the cart and disposed of the strip from the glucometer and placed the glucometer back on the cart without cleaning or disinfecting it. During an observation on 11/3/15 at 6:50 a.m., Licensed Staff H took the glucometer from the medication cart and took it in to Resident 4's room and placed it on the bedside table. Licensed Staff H lanced Resident 4's finger and brought the meter with the strip inserted up to Resident 4's finger to touch the blood from the finger. Licensed Staff H then took the meter back to the cart and disposed of the strip before putting the meter back in the cart. Licensed Staff H did not clean or disinfect the meter before putting it back in the cart drawer. During an interview on 11/3/15 at 7:40 a.m., Licensed Staff H stated that he cleaned the glucometers at night time with alcohol or the red disinfectant wipes, located on the bottom of the medication cart, but did not always clean after each resident use. During an interview on 11/3/15 at 4:55 p.m., Administrative Staff B stated that staff were supposed to use the red top disinfectant wipes to clean the glucometer between residents, to prevent the spread of blood bourne pathogens and infection between residents. On 11/3/15, review of the "Diabetic Care" policy revised 1/1/12, indicated that all licensed nurses should maintain blood glucose equipment per vendor recommendations. Review of the user	F 441	sanitizer to prevent cross contamination of surfaces or residents. 6. Bulk sterile containers were relocated on 11/3/15 to central supply. A small amount of sterile containers are in the medication room on the upper self away from any possible leakage of water from pipes. 7. DSD in-serviced nursing staff on 12/21/15 to assist visitors/family with obtaining water from medication cart or any medical supplies. **Monitoring:** The DSD will monitor the staff for infection control by using the Infection Control Checklist. 1. The Infection Control Preventionist will hold an Infection Control Meeting on 1/15/16 to discuss Infection Control related matters but not limited to	

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F 441	Continued From page 36 instruction manual for the blood glucose monitoring device indicated that contact with blood presents a potential infection risk and the meter should be cleaned and disinfected between patient use. Cleaning and disinfection is completed using a EPA, ("Environmental Protection Agency") disinfectant or germicide wipe. During an interview on 11/9/15 at 9:00 a.m., Administrative Staff C stated the facility followed CDC guidelines for infection control. Review of CDC (Centers for disease Control and Prevention) guidelines dated 5/2/12, indicated if blood glucose meters are shared, the device should be cleaned and disinfected after every use per the manufacturer's instructions to prevent carry-over of blood and infectious agents. The CDC guidelines indicated a risk of glucose testing is the opportunity for exposure to blood borne viruses (HIV (human immunodeficiency virus), hepatitis C virus...) through contaminated equipment and supplies if devices for testing are shared. 2. During an observation of the housekeeping closet on 11/9/15 at 8:20 a.m., there was an automatic mixer dispenser for the disinfectant cleaner. On the shelf next to the dispenser were containers of 3M (a global innovation company) concentrated cleaner for floors, resident rooms and bathrooms. During an interview at this time, Unlicensed Staff Q stated that she used the Quaternary disinfectant cleaner (cleans, disinfectants and deodorizes in one step. For use on hard, non-porous surfaces like floors, walls, toilet bowl surfaces, sinks, showers, lavatory fixtures, finished woodwork, vinyl and plastic upholstery, etc.) for cleaning resident beds and	F 441	(a) maintenance of sanitation or disinfection of the facility glucometers (b) appropriate use of disinfectant products (c) educational training needs of staff, volunteers or appropriate family members of resident on infection control and universal precautions and proper storage of bulk sterile containers. 2. Any trend or concerns identified by the Infection Control Committee based on their quarterly meeting or as needed meetings will be reported to the quarterly Quality Assurance Committee for further recommendations and or resolution.	

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F 441	Continued From page 37 put the solution in the spray bottle from the mixer, sprayed it on the resident bed and wiped it off. Unlicensed Staff Q stated she did not keep track of the time the solution stayed wet on the bed and didn't know how long it was supposed to be left wet on the bed to be a effective disinfectant. The label on the 3M Quat cleaner indicated it was to remain wet on the surface for 10 minutes to kill all organisms. During an interview on 11/9/15 at 10:50 a.m., Unlicensed Staff R, who was the supervisor for Unlicensed Staff Q, stated that each bottle of disinfectant cleaner had different contact times and staff should be aware of the contact times to ensure organisms were killed. During an interview on 11/9/15 at 1:55 p.m., Administrative Staff C stated that the contracted cleaning agency was supposed to train their staff on the disinfectants they use. On 11/9/15, review of the facility's contract with the housekeeping service company titled "Master Agreement for Services" dated 2/1/10, indicated the contractor was to oversee services provided, do quality control inspections and monthly in services of staff. On 11/9/15, review of the 3M HB Quat disinfectant cleaner technical data provided by the contractor, dated 8/12, indicated, in order for the cleaner to be used as a disinfect, distroy fungus and kill viruses, staff should use .35 ounces per gallon of water for hard non-porous surfaces and treated surfaces. The surfaces must remain wet for 10 minutes contact time to destroy viruses.	F 441		

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F 441	Continued From page 38	F 441		

Review of the orientation manual dated 10/14/08, for infection control, indicated that precautions designed to intercept transmission of infection included environmental control to ensure the health care establishment has adequate procedures for the routine care, cleaning and disinfection of the environmental surfaces, beds, bed rails, bedside equipment and other frequently touched surfaces and monitoring that these procedures are being followed.

3. During an observation on 11/3/15 at 6:06 a.m., Licensed Staff H removed his gloves and did not wash hands after checking Resident 11's blood sugar.

During an observation on 11/3/15 at 9:05 a.m., Licensed Staff K administered po (by mouth) medication to Resident 6 and prepared to administer medication to Resident 1. Licensed Staff K pulled up his pants, did not wash his hands or use hand sanitizer before administering medication to Resident 1.

During an observation on 11/3/15 at 11:30 a.m. Licensed Staff K checked Resident 5's blood sugar, took off his gloves and did not use hand sanitizer or wash his hands before he handled his keys and opened the medication cart drawer.

During an observation on 11/3/15 at 11:40 a.m., Licensed Staff M took his gloves off after checking Resident 12's blood sugar and did not wash his hands or use hand sanitizer before handling his keys and opening the medication drawer.

During an observation on 11/3/15 at 12:10 p.m., Licensed Staff K removed his gloves after

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F 441	Continued From page 39 administering insulin to Resident 13, and did not use hand sanitizer or wash his hands after removing the gloves. During an observation on 11/4/15 at 5:05 p.m., Licensed Staff K removed his gloves after checking blood sugar on Resident 5, and did not wash his hands before putting on another pair of gloves. On 11/4/15 at 5:45 p.m., Licensed Staff K took off his gloves after giving insulin to Resident 13 and did not wash his hands or use hand sanitizer before handling the drawers of the medication cart and putting on other gloves. When asked about washing hands after removal of gloves, Licensed Staff K stated that no one explained to him that he should sanitize his hands after taking off his gloves. During an interview on 11/9/15 at 1:50 p.m., Administrative Staff C stated when staff remove gloves they should wash their hands or use hand sanitizer, to prevent cross contamination of surfaces. Review of the "infection control" procedures from the orientation manual dated 10/14/08 indicated staff were to remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another patient. Staff must wash hands immediately to avoid transfer of microorganisms to other patients or environments. Review of the facility's "Hand Hygiene" policy and procedure dated 2/1/13 indicated that staff were to use alcohol-based hand hygiene to decontaminate hands after removing personal	F 441		

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F 441	Continued From page 40 protective equipment (gloves) and before moving to another resident in the same room or exiting the room. 4. During an observation of the medication room at the nurses station on 11/2/15 at 10:20 a.m., under a functioning sink in the cabinet was an open plastic bag of multiple containers with orange caps, and labels indicating they were sterile containers. During an interview at this time, Licensed Staff L stated that they were sterile containers for urine cultures and there were about 50 to 100 in the bag. Licensed Staff L stated that they were usually kept above the sink. Licensed Staff L stated the sterile urine cups should not be stored under the sink as a "leak from the pipes" could happen and contaminate the sterile containers. During an observation, Licensed Staff L then removed the cups and placed them on the counter above the sink. During an observation on 11/5/15 at 8 a.m., the sterile urine specimen containers that were in the open plastic bag remained under the sink. During an interview on 11/10/15 at 5 p.m., Administrative Staff A stated the facility did not have a policy and procedure for storage of sterile supplies. During an interview on 11/9/15 at 9 a.m., Administrative Staff C stated the facility followed CDC guidelines for infection control. Review of CDC guidelines for the disinfection and sterilization in healthcare facilities dated 2008, indicated medical supplies should not be stored under sinks or in locations where they can become wet as sterile items that become wet	F 441		

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

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F 441	Continued From page 41 become contaminated, as moisture brings microorganisms from air and surfaces. 5.During a concurrent observation and interview on 11/2/15, at 12:30 p.m., a resident's family was assisting the resident for lunch in the dining room. The family stated the facility did not provide water in the dining room sometimes. At 12:35 p.m., the family asked a CNA (Certified Nursing Assistant) who was assisting a resident at a different table for water. The CNA did not leave the table to provide water to the family. The family went to a medication cart in front of room 2 and obtained water from a water container without staff assistance while a staff was working at the medication cart. The family did not wash hands between assisting the resident and obtaining water from the medication cart. During an interview on 11/10/15, at 9:15 a.m., Administrative Staff C stated staff should help the family for obtaining water because of infection control and minimizing the spread of infection. Review of the facility's "Hand Hygiene" policy and procedure dated 2/1/13 indicated that Facility staff, visitors and volunteers must perform hand hygiene procedures before eating, before and after food preparation and before and after assisting residents with dining if direct contact with food is anticipated or occurs.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	**F514** **Corrective Action/s:** Medical Records Director (MRD) will audit Medication Administration Record (MAR) and Treatment Administration Record (TAR) for missing documentation. Director of Nursing (DON) immediately investigated the missing documentation on the MAR for resident 5 and 14 and interviewed staff involved. The	12/31/15

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F 514	Continued From page 42 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure documentation was complete and accurate for two of 16 sampled residents (Resident 5 and 14). This failure had the potential to prevent physician and other staff to review and provide appropriate care for the residents. Findings: During a concurrent interview and record review on 11/3/15, at 3:05 p.m., Resident 14's medication administration record (MAR) undated, had documentation for administering regular insulin from the 2nd to the 4th of the month. The 1st of the month was blank. Licensed Staff K stated the MAR was for November 2015 and the staff missed the documentation for 11/1/15; the MAR indicated insulin administration for 11/4/15 when record review on 11/3/15. Licensed Staff K stated he would ask the director of nursing to correct the MAR. A review of MARs revealed missing documentation for Resident 14's Lantus insulin	F 514	November MAR has been corrected to be readable on 11/3/15. **How to Identify Other Residents:** 1. Medical Records Director (MRD) will audit all residents' Medication Administration Record (MAR) and Treatment Administration Record (TAR) for missing documentation. 2. Director of Nursing (DON) will review the MAR and TAR audit weekly for timely completion by licensed nurses. 3. Medical Records Director will re-audit MAR and TAR for completion and corrections. 4. In-service provided by DON to licensed nurses regarding completion of MARs and TARs on 12/21/15.	

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F 514	Continued From page 43 on 9/12/15 at 9 p.m., Resident 5's Novolog insulin and Lantus insulin on 9/22/15 and 10/27/15 at 8 p.m. and 9 p.m., and Resident 5's Keppra (medication for seizure disorder) on 10/22/15 at 9 a.m. During an interview on 11/10/15, at 10:45 a.m., Administrative Staff B acknowledged the missing documentation. The facility's policy and procedure titled "Completion & Correction," revised 1/1/12, indicated "Purpose To ensure that medical records are complete and accurate...Entries will be complete, legible, descriptive and accurate...Medication administration...Name, dosage and time of administration...Rout of administration if other than oral...Injection site..."	F 514	**Systemic Changes:** MRD will audit the MAR and TAR weekly for completion. Results of audit will be placed in audit binder and copy given to DON for review. **Monitoring:** Monitoring will be done through the audit process. DON/nursing supervisor will review weekly and validate completion of documentation.	
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one out of four persons interviewed was aware of how to use a fire extinguisher in the event of a fire. Findings: During an interview and observation on 11/9/15 at	F 518	Any trend identified based on the audit will be forwarded by Medical Records Supervisor to the quarterly Quality Assurance meeting for further review and correction as needed. **F518** **Corrective Action/s:** Director of Staff Development (DSD) provided in-service to staff on the use of fire extinguisher on 11/12/15.	1/8/16

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F 518	Continued From page 44	F 518		

8:15 a.m., Unlicensed Staff Q stated that the facility showed her where the fire extinguishers were located, as she pointed to the fire extinguisher in the hallway across from dinning room, and stated that the word "PASS" indicated how to use it, you pull the pin, aim at the fire, squeeze the handle and sweep side to side. Unlicensed Staff Q looked at the fire extinguisher handle, and stated she didn't know what the pin was, on the fire extinguisher and pointed to the spray handle as the pin. Unlicensed Staff Q stated that the facility never actually showed her how to use it.

On 11/10/15, Review of the employee safety general responsibilities dated 12/11/14 which was part of orientation indicated that staff were to learn to operate the extinguishers and know their locations.

Review of the Orientation to Fire Safety & Disaster Preparedness policy dated 1/1/12, indicated Facility staff, including volunteers, students, and other trainees, must participate in an orientation regarding the Fire Safety and Disaster Preparedness plans. Fire safety classes include instructions for the use of fire extinguishers and fire fighting procedures.

How to Identify Other Residents:

DSD will provide an in-service during orientation, quarterly and annually on how to use the fire extinguisher.

Systemic Changes:

1. Employee files of newly hired staff will be reviewed by the Administrator or designee to validate completion of training of new staff.
2. Staff Developer will share with the Administrator staff participation/attendance on these ongoing training on the use of fire extinguisher.

Monitoring:

Trends and or patterns of concerns identified by the DSD will be reported to the monthly Quality Assurance Committee for further review and recommendations.