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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. BUILDING ______ B. WING ______	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUPERTINO HEALTHCARE & WELLNESS CENTER	22590 VOSS AVENUE CUPERTINO, CA 95014

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH FEB 15 2017 L & C DIVISION SAN JOSE

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 1/17/17 through 1/20/17. This was conducted in conjunction with the relicensing survey. The facility was licensed for 170 beds. The census at the time of the survey was 165. The sample size was 25. Two deficiencies, F314, 483.25(c), and F323, 483.25(h), were at a scope and severity of "G." In addition, two Class "B" Citations were issued for both tags. Representing the California Department of Public Health: 32892, Health Facilities Evaluator Nurse; 29765, Health Facilities Evaluator Nurse; 34383, Health Facilities Evaluator Nurse; 35157, Health Facilities Evaluator Nurse; and 35091, Health Facilities Evaluator Nurse.	F 000	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 provisions of federal and state law.	2/19/17
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph	F 226	**F226** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Reference checks for LVN Z will be obtained, by the DSD by 2/19/17 **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:** An in-service will be held by the DSD with Department Head's regarding reference checks for employees by 2/19/17. Upon hiring the DSD/DH/Designee will check references of employees prior to being placed on the floor to work. DSD will audit the reference checks upon hire.	2/19/17

L[redacted] SIGNATURE [redacted] (X6) DATE 2/14/17

A[redacted] which the institution may be excused from correcting providing it is determined that o[redacted]ions.) 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.

2/15/17 POC accepted

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F 226	Continued From page 1 §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their abuse policy and procedure when one of five recently hired staff members did not have two reference checks upon hire. This failure had the potential for a staff member with a history of abuse to work with the residents. Findings: A review of licensed vocational nurse Z's (LVN Z) personnel file indicated there were no reference check done upon hire. During an interview with the director of staff development (DSD), on 1/17/17, at 10 a.m., she confirmed one employee did not have a reference check upon hire.	F 226	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The DSD will prepare each new employee file during orientation; a check list will be used to ensure all items required in the file are present. The Administrator will sign off on all employee files, after they are completed to ensure compliance. A report of new hires will be prepared for the facility quarterly QA process. **How the facility plans to monitor its performance to make sure that solutions are sustained:** A report on new hires will be presented by the DSD and part of the facility quarterly QA and until compliance is achieved.	2/19/17 2/19/17

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F 226	Continued From page 2 During an interview with the DSD on 1/17/17, at 11:30 a.m., she stated all new employees need two reference checks upon hire. The facility's undated policy and procedure titled "Abuse Prevention Program" indicated at least two reference checks from previous or current employers are obtained prior to hiring an applicant.	F 226		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate the resident's preference for one non-sampled resident (32) when the preferred size of incontinence pads was not provided. This had the potential to affect his physical and/or emotional well-being. Findings: During an initial tour on 1/17/17 at 8 a.m., Resident 32 stated he preferred using a large size of incontinence pad. He stated on several occasions staff placed a larger pad and it slid down when he pulled himself up in bed. He stated at times staff used a smaller pad and it was uncomfortable.	F 246	**F246** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** IDT will assess resident 32 for the ability of using a larger brief per his request and his safety in using the larger brief by 2/19/17 Resident #32 brief was provided as requested, after being verified by the IDT that it didn't cause a potential harm and safety issue. CP will be updated by nursing by 2/19/17 **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:** The facility will contact the brief company to come and have their representative do an in-service with the CNA's related to brief sizing, to ensure appropriate and safest brief is being used. A list of appropriate sizes for the residents will be obtained by the brief representative, to ensure the appropriate and safest brief is being used.	2/19/17 2/19/17

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F 246	Continued From page 3 Review of Resident 32's clinical record indicated he was cognitively intact. His 12/2016 minimum data set (MDS, an assessment tool) indicated he was totally dependent on staff for his toileting needs. During an observation and interview with certified nursing assistant M (CNA M) on 1/19/17 at 1 p.m., she showed different sizes of incontinence pads. She stated Resident 32 preferred the yellow pad which was the extra large incontinence pad and he did not want a smaller or a larger pad. During an interview with CNA N on 1/19/17 at 1:20 p.m., he stated the facility ran out of the extra large incontinence pads and staff had to use a different size. During an interview with licensed vocational nurse J (LVN J) on 1/20/17 at 1:25 p.m., she stated she was not aware of Resident 32's preference. She stated it should have been communicated to staff. During an interview with the director of nursing (DON) on 1/20/17 at 7:50 a.m., she stated Resident 32's preference should have been documented and communicated between staff to make sure the facility did not run out of the resident's preferred size of pad. Review of the facility's 1/2012 policy "Resident Rights - Accommodation of Needs" indicated individual needs and preference would be accommodate to the extent possible.	F 246	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The central supply coordinator will randomly ask 2-4 residents weekly regarding their briefs and the fit of the briefs. A log will be kept of resident responses. A QAPI will be developed from the log. The brief company will come twice a year to re-size the residents. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will become part of the facility quarterly QA meeting and until compliance is achieved.	2/19/17 2/19/17
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 4 (i)(2) 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 provide effective housekeeping and maintenance when the blinds on residents' windows and patio doors had several missing slats, curtains were not properly hung, there was a gap in between the window and window frame, and a resident toilet was clogged. This practice had the potential to cause an unpleasant and unsanitary environment. Findings: 1. During the initial tour on 1/17/17 at 7:45 a.m., room D was observed and the door blinds were missing four slats. The window blinds in room E had five slats missing. During an environmental tour with the director of maintenance (DM) and assistant maintenance (AM) on 1/17/17 at 2 p.m., rooms E, D, and G were observed. The window blinds were missing slats. In room C, window blinds were missing six slats, and door blinds were missing three slats. During an interview with the DM on 1/17/17 at 2 p.m., he confirmed the above findings. He stated the blinds which were missing slats needed to be replaced. 2. During the initial tour on 1/17/17 at 7:40 a.m., the curtains in rooms C and E were hung but there were no hooks attached. During an environmental tour with the DM and the	F 253	**F253** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** The items identified in the 2567 were repaired by the maintenance department during survey (1/20/17) **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:** The DSD/Designee will give an in-service to the nursing staff regarding the use of the maintenance log book and reporting issues by 2/19/17 **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** Department Heads will be conducting rounds weekly to monitor for compliance. Any issues identified on the rounds will be placed in the maintenance log book. Repeat issues will be brought to the morning stand up meeting to discus and a QAPI developed if needed.	2/19/17 2/19/17 2/19/17

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F 253	Continued From page 5 AM on 1/17/17 at 2 p.m., rooms A, B, C, D, and E were observed. Hooks were missing from the curtains, curtain hooks were entangled, and the curtains were not properly hung. During an interview with the DM on 1/17/17 at 2 p.m., he confirmed the above observation. He stated staff should check the curtains to make sure they were properly hung. 3. During the initial tour on 1/17/17 at 8:15 a.m., Resident 47 complained about the gap in between the window and the window frame. During an environmental tour with the DM and the AM on 1/17/17 at 2:30 p.m., Room F had a gap in between the window and the window frame allowing air to enter the room. During an interview with Resident 47 at 1/17/17 at 2:35 p.m., he stated at night the cold air entered his room and it was uncomfortable. He stated he told the staff regarding this for several weeks. During an interview with the DM on 1/17/17 at 2:40 p.m., he stated the window should be fixed to prevent cold air from entering the room. Review of the facility's 1/2012 policy "Resident Rooms and Environment," indicated the facility would provide a safe, clean, comfortable, and homelike environment. Staff will provide residents with a pleasant environment which emphasizes the resident's comfort. 4. During the initial tour on 1/17/17 at 7:45 a.m., Resident 14 complained he had a "busted toilet" (clogged toilet) since 1/13/17 and had told staff about it.	F 253	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA program and until compliance is achieved.	2/19/17

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F 253	Continued From page 6 During an environmental tour with the DM and the AM on 1/17/17 at 2 p.m., Resident 14's toilet was filled with water and feces, and the toilet would not flush. During an interview with the DM on 1/17/17 at 2 p.m., he stated staff should inform housekeeping or maintenance so it could be fixed. During an interview with licensed vocational nurse D (LVN D) on 1/19/17 at 3:30 p.m., she stated she was informed of Resident's 14 clogged toilet on 1/16/17 but she did not write the concern in the maintenance log book. During an interview with the director of nursing on 1/20/17 at 7:30 a.m., she stated staff should write any maintenance problem in the log book so it could be fixed. Review of the facility's 1/2012 policy "Housekeeping-Residents room" indicated the facility would promote the quality of life for residents by providing a clean and sanitary environment. Housekeeping staff would coordinate the daily cleaning of all resident rooms including residents restrooms.	F 253		
F 257 SS=D	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 257	**F257** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Social Services will meet with residents 11, 21, 38, 37, 41, 39 to discuss room temperature and identify individual issues that may exist by 2/19/17	2/19/17

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F 257	Continued From page 7 review, the facility failed to provide a comfortable room temperature for two sampled residents (11 and 21) and four non-sampled residents (37, 38, 39, and 41) when the thermostat (a system which senses the temperature and automatically turns the air conditioner or heater on and off to maintain the desired temperature) was off. This had the potential to cause discomfort to the residents. Findings: 1. During an interview with Resident 11 on 1/17/17 at 3:10 p.m., she stated it was cold all the time in her room. Resident 11 stated usually around 3 a.m., it felt like there was no heat in the room. She stated the staff were aware because she always asked for extra blankets. 2. During the initial tour on 1/17/17 at 8:01 a.m., Resident 21 was observed with three layers of blankets over her body. She stated, "It was cold in my room." She stated she communicated her concern to facility staff. Resident 21's clinical record was reviewed. Her MDS dated 9/28/16, indicated she had no cognitive impairment. Resident 21 was able to verbalize her needs. During a group interview on 1/18/17 at 10 a.m., Resident 21, Resident 38, Resident 37, and Resident 41 stated their rooms were cold especially at night time. Resident 39 stated if the thermostat was off it made her room cold. During an environmental tour observation with director of maintenance (DM) and assistant maintenance (AM) on 1/17/17 at 2 p.m., the	F 257	**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:** The facility maintenance department will place locks on all the thermostats in the facility by 2/19/17. The keys will be limited to specific employees. The above mentioned residents will be interviewed weekly by social services/designee to discuss the room temperature and ensure that the corrective actions are working by 2/19/17 A log will be kept by social services by 2/19/17 **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** Administrator will do weekly rounds to ensure that the thermostats are locked and set at the correct temperature. The ADM will randomly interview 5 residents a week for 1 month, then 5 monthly, then 5 quarterly. A QAPI will be developed according to the results.	2/19/17 2/19/17

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F 257	Continued From page 8 thermostat near room A was off. During an interview with the AM on 1/17/17 at 2 p.m., he stated staff had turned off the thermostat and it should not be. He stated the thermostat should be turned on so it could automatically switch the heating and cooling device on or off to maintain the desired temperature for the residents. Review of the facility's 1/2012 policy "Resident Rooms and Environment" indicated the facility would provide a safe and comfortable environment. Staff would aim to create a personalized and homelike atmosphere which includes comfortable temperatures.	F 257	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be come part of the facility quarterly QA meeting.	2/19/17
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to determine a significant change in status assessment (SCSA, a significant change is a decline or improvement in a resident's status	F 274	**F274** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 22's MDS will be updated by the MDS nurse by 2/19/17 **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:** RAC RN conducted an audit on 2/9/17 of all residents receiving hospice care. MDSC will review coding issues, confirm and modify as appropriate. All SCSA for current	2/19/17

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F 274	Continued From page 9 which will normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting) within 14 days for one of 25 sampled residents (22) when Resident 22 was enrolled in hospice care. This failure could affect the resident's care. Findings: Review of Resident 22's clinical record indicated the resident was admitted to hospice care on 9/9/16 with terminal diagnosis of cerebral arteriosclerosis (artery disease characterized by plaque deposits of fatty materials of the inner walls). Review of Resident 22's minimum data set (MDS, an assessment tool) indicated on 8/1/16 a quarterly assessment was completed. There was no MDS for SCSA within 14 days after Resident 22 had enrolled in hospice care. During an interview with the minimum data set coordinator (MDSC) on 1/19/17 at 4:10 p.m., she stated the SCSA was required when Resident 22 enrolled in hospice care. She also stated the SCSA should have been done within 14 days from the enrollment date in hospice care. Review of the facility's RAI manual 4/2012, "Chapter 2: Assessment for RAI," indicated the SCSA was required to be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the nursing home. The assessment reference date must be within 14 days from the effective date of the hospice election.	F 274	hospice residents will be completed by 2/19/17. **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** MDSC will attend stand up meetings and review census to monitor hospice enrollment and disenrollment. Facility will hire an interim MDS nurse to assist in completing outstanding MDS assessments. MDSC will inform the IDT of pending MDS assessments requiring completion. All ARD's after 2/19/17 will be completed timely per RAI guidelines. The MDSC will provide a list of outstanding MDS to the administrator on a weekly basis to ensure timely scheduling and completion of MDS. Any trends identified will have a QAPI developed to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA process and until compliance is achieved.	2/19/17 2/19/17

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F 275	Continued From page 10	F 275	**F275**	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a comprehensive assessment for one of 25 sampled residents (Resident 19) when the resident's annual assessment was not completed within 12 months after the completion of the most recent comprehensive assessment. This failure could lead to the resident's needs not being addressed. Findings: Review of Resident 19's minimum data set (MDS, an assessment tool), indicated her comprehensive assessment was completed on 10/9/15 as a significant change assessment in a resident's status. There was no comprehensive annual assessment. During an interview with the minimum data set coordinator (MDSC) on 1/19/17 at 2 p.m., she stated Resident 19's comprehensive annual assessment was scheduled on 10/6/16 but it was not completed. She also stated Resident 19 should have a comprehensive annual assessment.	F 275	**How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 19's MDS will be updated by the MDS nurse by 2/19/17 **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:** RAC resource nurse conducted an audit on 2/10/17 of all active residents to identify residents having potential to be affected. Facility will hire an interim MDS nurse to assist in finishing outstanding MDS assessments. MDSC will review MDS assessment summary report weekly. MDSC will inform the IDT of pending MDS assessments requiring completion. All ARD's after 2/19/17 will be completed timely per RAI guidelines. **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:**	2/19/17 2/19/17

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F 275	Continued From page 11 A review of the facility's policy on "Resident Assessment Instrument (RAI) Omnibus Budget Reconciliation Act (OBRA, 1987, also known as the Nursing Home Reform Act), Required Assessment Summary" dated 10/13, indicated the assessment reference date of previous comprehensive annual assessments plus 366 calendars days for the next comprehensive annual assessment.	F 275	The MDSC will provide a list of outstanding MDS to the administrator on a weekly basis to ensure timely scheduling and completion of MDS. . Any trends identified will have a QAPI developed to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance	2/19/17
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the residents' assessments were done on a quarterly basis for Residents 3, 4, 5, 6, 9, 11, 13, 17, and 21. These failures could potentially affect the development and modification of care plans, provision of care or services for each resident. Findings: 1. A review of the minimum data set (MDS, an assessment tool) for Residents 11 and 17 was done. Resident 11's last quarterly review was completed on 9/7/16. The next quarterly MDS should have been completed on 12/16 but it was not done. Resident 17's last quarterly review was done on 7/16. The next quarterly review would have been due on 10/16 but was not completed.	F 276		

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F 276	Continued From page 12 During an interview with minimum data set coordinator (MDSC) on 1/18/17 at 1:30 p.m., she stated MDS quarterly assessments should have been completed as required for Residents 11 and 17. 2. Resident 13's clinical record was reviewed. Her MDS assessment indicated she did not have the capacity to make decisions. The record also indicated the resident had a witnessed fall on 6/10/16, and the nursing weekly summary indicated both fall and skin risk factors for Resident 13. A review of the resident's quarterly risks assessments indicated the Braden Scale, a tool for predicting pressure sore risk; Fall Risk assessment and Bowel and Bladder Assessment were not done quarterly as required. The last documented assessments were done on 8/2/16. During an interview with the licensed vocational nurse O (LVN O) on 1/17/17 at 5 p.m., she stated the assessments should be done quarterly. During an interview with assistant director of nursing (ADON) on 1/18/17 at 12:30 p.m., she confirmed Resident 13's quarterly assessments for pressure sore risk, fall risk and bowel and bladder assessments were not done as required. A review of the facility's policy on Fall Management Program, revised on 11/7/16, indicated "...the interdisciplinary team [IDT, a team who meets regularly to discuss resident's care] will initiate, review, and update resident fall risks at the following intervals: admission, quarterly, annually, upon significant change of	F 276	**F276** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Residents 3, 4,5,6,9, 11, 13, 17, and 21 quarterly MDS assessments will be completed by 2/19/17 **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:** RAC resource nurse conducted an audit on 2/10/17 of all active residents to identify residents having potential to be affected.	2/19/17

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F 276	Continued From page 13 condition and post fall as needed." A review of the facility's policy "Pressure Injury Prevention," revised on 8/12/16, indicated "...the skin assessments are done on admission, weekly for four weeks, quarterly, and when there is a change in condition." A review of the facility's revised policy on Bowel and Bladder Training/Toileting Program, dated 7/3/14, indicated "...the Licensed Nurse will assess residents' bowel and bladder status within fourteen days of admission, quarterly, annually, upon change of condition, and upon removal of indwelling catheter." 3. Resident 3 was admitted to the facility with diagnoses including multiple sclerosis (nervous system disease that affects the brain and spinal cord). The Minimum Data Set (MDS, an assessment tool) dated 7/13/16 indicated Resident 3 was able to make decisions for himself. Resident 3 needed extensive care for the activities of daily living except for eating wherein he needed supervision only. There was no other quarterly assessment done documented in the clinical record. During an interview with the MDSC on 1/18/17 at 2:00 p.m., she stated there was no latest quarterly MDS done for Resident 3. 4. Resident 6 was admitted to the facility with diagnoses including diabetes mellitus (a group of metabolic diseases in which the person has high blood sugar). The MDS dated 6/3/16 indicated Resident 6 was cognitively intact. Resident 6 needed supervision only in the activities of daily living. There was no other quarterly assessment	F 276	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** Facility will hire an interim MDS nurse to assist in completing outstanding MDS assessments. MDSC will inform the IDT of pending MDS assessments requiring completion. All ARD's after 2/19/17 will be completed timely per RAI guidelines. MDSC will provide a lost of the outstanding MDS to the administrator on a weekly basis to ensure timely scheduling and completion of MDS. Any trends will be identified and a QAPI will be developed. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved	2/19/17 2/19/17

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documented in the clinical record.

During an interview with MDSC on 1/18/17 at 2:00 p.m. she stated there was no latest quarterly MDS done for Resident 6.

5. Resident 5's clinical record was reviewed and her latest completed MDS was on 7/20/16. There was no quarterly assessment completed for 10/2016.

During an interview with MDSC on 1/18/17 at 3 p.m., she stated Resident 5's MDS quarterly assessment should have been completed on 11/2016.

6. Resident 4's clinical record was reviewed and indicated he was admitted on 7/29/16. His latest MDS was dated 9/9/16. There was no quarterly assessment completed on 12/2016.

During an interview with MDSC, on 1/19/17 at 8:15 a.m., she stated Resident 4's quarterly MDS should have been completed in December 2016.

7. Resident 21's clinical record was reviewed and indicated her latest MDS was completed on 9/28/16. There was no quarterly assessment completed in 12/2016.

During an interview with MDSC, on 1/19/17 at 8:15 a.m., she stated Resident 21's quarterly MDS should have been completed on December, 2016.

8. Review of Resident 9's clinical record indicated the resident was admitted on 9/11/16 with diagnosis including dementia (memory problem), muscle weakness and cognitive communication

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F 276	Continued From page 15 deficit. His minimum data set (MDS, an assessment tool) dated 10/9/16, indicated the resident had impaired cognition, required assistance with bed mobility, transfer, hygiene and bathing. There was no quarterly review assessment available in 12/2016. During an interview with MDSC on 1/17/17 at 1:40 p.m., she stated Resident 9's quarterly assessment was scheduled on 12/15/16 and it was not completed. She also stated Resident 9 should have a quarterly assessment. A review of the facility's policy on "Resident Assessment Instrument (RAI) Omnibus Budget Reconciliation Act (OBRA, passed 1987 also known as the Nursing Home Reform Act), Required Assessment Summary" dated 10/13, indicated for quarterly (non-comprehensive) assessment, the assessment reference date (ARD) should be no later than the ARD of previous OBRA assessment of any type + 92 calendar days.	F 276		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278	**F278** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Residents 20 will have updated MDS assessment by the MDS nurses by 2/19/17 and residents 7 and 15 will have quarterly assessments with ARD 2/2/17 completed by the MDSC by 2/19/17.	2/19/17

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F 278	Continued From page 16 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents' assessment were accurate for three sampled residents. For Residents 7 and 15, some sections of the minimum data set (MDS, an assessment tool) had missing information. For Resident 20, the MDS did not accurately reflect the resident's health status. These failures could potentially affect the development and modification of care plans, and provision of care or services for each resident. Findings: 1. Review of Resident 7's MDS dated 11/3/16 indicated some missing information for some	F 278	**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:** RAC RNC completed an audit on K05108 on 2/10/17 for all current residents that are receiving tube feeding. **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The RAC RNC provided an in-service with the DSS on accurately coding sections K0510 on 2/9/17. RAC RNC provided an in-service with MDSC on timely completion and accurately coding interview sections of the sections C & J of the MDS on 2/9/17 and 2/14/17. Facility will hire an interim MDS nurse to assist in completing outstanding MD assessments. All ARD's after 2/19/17 will be completed timely per RAI guidelines. MDSC will review assessment summary report weekly and inform IDT of pending MDS assessments requiring completion.	2/19/17 2/19/17

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F 278	Continued From page 17 sections of the MDS. During an interview with MDS coordinator (MDSC) on 1/19/17 at 10:20 a.m., she stated staff were not able to complete some sections of the MDS. She stated staff were late in completing the MDS so there was missing information. 2. Resident 15's clinical record was reviewed. Her MDS dated 11/3/16 indicated some missing information for some sections of the MDS. During an interview with MDSC on 1/19/17 at 10:25 a.m., she confirmed the missing information in the MDS. She stated the resident interview section of the MDS was done after the assessment reference date (ARD, the specific end point of look-back periods in the MDS assessment process) and it should be done on or before ARD. She stated there was missing information in the MDS as staff did not do the MDS timely. She stated staff should complete all sections of the MDS and it should be done timely. 3. Review of Resident 20's MDS was done. The MDS indicated a significant change assessment was completed on 10/22/16. Resident 20 was originally admitted on 8/12/16 with diagnoses including encephalopathy (a disease that affects brain function), CVA (cerebral vascular accident, a stroke), and end stage kidney failure. Resident 20 was sent to the hospital admitted from 9/26/16 to 10/15/16 for altered level of consciousness. The resident had a percutaneous endoscopic gastrostomy (PEG, placement of a tube through the abdominal wall into the stomach for nutritional support) procedure done at the hospital. Further review of the MDS completed on	F 278	**How the facility plans to monitor its performance to make sure that solutions are sustained:** This will become part of the facility quarterly QA meeting and until compliance is achieved.	2/14/17

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F 278	Continued From page 18 10/22/16, did not include feeding tube, nasogastric or abdominal (PEG) under Section K 0510. Nutritional Approaches. During an interview with MDSC on 1/19/17 at 2:30 p.m., she confirmed the MDS should have included the PEG tube feeding to reflect accuracy of the resident's status. Review of the facility's 10/2016 policy "Resident Assessment Instrumentation (RAI) Process" the facility would utilize the RAI as the basis for accurate assessment of each resident's functional capacity and health status. Designated staff should complete each section of the MDS.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 279	**F279** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Residents 1, 12, 15, 20, and 21 their CP's will be updated by nursing **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:** The DSD/DON/Designee will give an in-service with the LN's regarding CP for CPOD, PICC line length, falls, and quentiapine used for sleep. Medical records will print out a list of residents with the DX of COPD, PICC lines, and Quentiapine usage. The CP's of these residents will be updated by nursing	2/19/17 2/19/17

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F 279	Continued From page 19 care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 279	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** Every quarter the MR's will print out a list of the residents with the above mentioned conditions and the IDT will review the CP's in the quarterly CP meeting. A copy of the CP's completed will be given to the ADM quarterly, to ensure every resident has had a CP review. **How the facility plans to monitor its performance to make sure that solutions are sustained:** This report will be part of the facility quarterly QA meeting and until compliance is achieved.	2/19/17 2/19/17

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Based on observation, interview, and record review, the facility failed to develop, review, revise and implement care plans for 5 of 25 sampled residents (2, 12, 15, 20, and 21).

For Resident 21, care plan for respiratory issues was not developed; no care plan for Resident 2 was developed for peripherally inserted central catheter (PICC line, a long catheter introduced through a vein in the arm). Resident 15's care plan was not appropriately revised and reviewed after repeated falls. Resident 12's care plan for quentiapine (antipsychotic medication) was not developed, and Resident 20's falls care plan was not implemented.

These practices could result in the inability to identify and individualize care issues and services to meet the resident's needs.

Findings:

1. During the initial tour on 1/17/17 at 8:01 a.m., Resident 21 was on oxygen inhalation via nasal cannula (a plastic tubing used to deliver oxygen through the nose). She stated, "I have been on oxygen for a while because of my COPD" (Chronic Obstructive Pulmonary Disease, a chronic respiratory disorder.)

Resident 21's clinical record was reviewed. Her minimum data set (MDS, an assessment tool) dated 9/28/16, indicated she had no cognitive impairment. Resident 21 was readmitted on 11/19/16, with COPD. A physician order dated 11/19/16, indicated to administer oxygen continuously at 3 liters per minute.

During record review and interview with the

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F 279	Continued From page 21 assistant director of nursing (ADON), on 1/20/17 at 8:20 a.m., she stated there was no care plan developed for Resident 21's respiratory issues. The ADON stated licensed nurses should develop a care plan based on Resident 21 assessment of needs. 2. Resident 2 was admitted to the facility with diagnoses including cellulitis of the third finger (bacterial infection involving the inner layers of the skin). Resident 2 had a PICC line (peripherally inserted central catheter, a long, thin tube that enters the body through a vein in the upper arm) for infusion of antibiotics (antimicrobial drug used in the treatment and prevention of bacterial infections). During review of Resident 2's nursing care plan on 1/17/17, there was no care plan documented for the PICC line in the clinical record. During an interview on 1/18/17, at 3:15 p.m., with registered nurse K (RN K), he acknowledged there was no care plan for the PICC line and there should have been one. During an interview on 1/20/17, at 9:50 a.m. with the RN consultant (RNC), he stated he would obtain the PICC line length from admission and start the care plan for the PICC line. Review of the facility's policy and procedure on 1/20/17 "PICC Dressing Change" indicated to change dressing weekly. The length of the external catheter is obtained upon admission and document with dressing change record. 3. Review of Resident 15's clinical record indicated her diagnosis including multiple	F 279		

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sclerosis (a nervous system disease which could cause muscle weakness and trouble with coordination and balance).

Further review of her clinical record indicated she had seven falls since 8/20/16. Her most recent fall was 1/16/17 causing a wound on the lower leg. Her fall care plan had no new interventions planned or implemented to prevent future falls or minimize an injury.

During an interview with the director of nursing (DON) on 1/20/17 at 7:50 a.m., she stated Resident 15 was a high risk for fall related to her MS. She had a poor safety judgment, and she overestimated her capacity. DON stated the care plan should have been reviewed and a new intervention should have been developed and implemented to prevent falls.

Review of the facility's 11/7/2016 policy, "Fall Management Program," indicated the facility will implement a fall management program. Staff would develop a plan of care according to the identified risk factors and root cause. Staff would evaluate the resident's response to the plan of care and update care plan as necessary.

4. Review of Resident 12's clinical record indicated he was admitted on 12/28/16 with a diagnosis of psychosis (mental disorder). Her MDS dated 1/4/17, indicated the resident was cognitively intact.

Review of Resident 12's physician order dated 12/28/16, indicated an order of quentiapine (antipsychotic medication) 50 milligrams (mg, unit of measurement) one tablet once a day for psychosis.

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During an interview with the director of nursing on 1/18/17 at 12:30 p.m., she confirmed there was no care plan for quentiapine medication. She stated Resident 19 should have a care plan.

5. A review of Resident 20's clinical record indicated she had non-witnessed falls on 10/16/16 and 11/11/16, with no injury. Her MDS assessment of her cognitive skills indicated she had moderate impairment. Her fall risk assessment score was 18, indicating she was a high risk for fall (total score of 10 or above).

A review of her post-fall short term care plan approaches or interventions, included among others, a low bed and a landing pad, a soft mattress placed on the floor next to the bed. A review of the resident's long term care plan, "Fall Risk Prevention and Management," indicated Resident 20 had episodes of constantly moving around when in bed. One of the interventions was to provide a landing pad.

During an observation on 1/20/17 at 8 a.m., Resident 20 was laying on a low bed but there was no landing pad on the floor next to her bed. During another observation on 1/20/17 at 8:15 a.m., there was no landing pad on the floor.

During a concurrent interview in the resident's room with licensed vocational nurse D (LVN D) and licensed vocational nurse O (LVN O), both acknowledged the landing pad should have been in place as indicated in the care plan.

During an interview with the DON on 1/20/17 at 4 p.m., she stated there should have been a landing pad on the floor as indicated in the Fall

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F 279	Continued From page 24 care plan. A review of the facility's 11/16 "Care Planning" policy, indicated a licensed nurse should initiate a care plan for the resident in accordance with the initial assessment of the resident's medical, nursing, mental, and psychosocial needs. In addition, a care plan may be initiated upon identification of a change of condition and/or new needs.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the nursing services met the professional standards of quality for six of 25 sampled residents (2, 8, 15, 16, 20, and 25) and one nonsampled resident (26). For Resident 2, the PICC (peripherally inserted central catheter, a long, thin tube that goes enters the body through a vein in the upper arm) was not measured for length during admission and during each dressing change. For Resident 8, the medications were not explained before medication administration and no pain assessment was done before giving the pain medication. For Residents 15, 20, and 25, there were no fall neurological assessments done after the falls. For Resident 26, the medications were	F 281	**F281** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 2 PICC line will be measured from the site to the hub by nursing. Residents 2 and 16 care plan will be updated by the nursing staff; resident 8 will be assessed for pain by nursing , and 15, 20, and 25 will have neurological assessments done by the nursing staff.	2/19/17

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F 281	Continued From page 25 not explained before administration. These failures may affect the quality of care and safety of the residents in the facility. Findings: 1. Resident 2 was admitted to the facility with diagnoses including cellulitis of the third finger (bacterial infection involving the inner layers of the skin). Resident 2 had a PICC line for infusion of antibiotics (antimicrobial drug used in the treatment and prevention of bacterial infections). During review of Resident 2's clinical record on 1/17/17, the "intravenous therapy medication record" did not have the note indicating the PICC size and the catheter length for the internal and external length of the catheter. During an interview with the registered nurse consultant (RNC) on 1/20/17 at 10:35 a.m. he acknowledged there was no measurement of the catheter length documented in the resident's clinical record. Review on 1/20/17 of the facility's policy and procedure "PICC Dressing Change" indicated to document the length of the external catheter upon admission and during dressing changes. 2. Resident 16's clinical record was reviewed on 1/19/17, the physician order dated 1/2017 indicated Resident 16's diet was puree with thin liquids and the family may bring foods from home. During observation of Resident 16 in his room on 1/17/17, 1/18/17, and 1/19/17, at his bedside the resident had plastic containers containing regular	F 281	**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:** An in-service will be held with LN's regarding using the examples from the survey. RN supervisor will measure the length of PICC for residents admitted with PICC line. The DON will review residents with unwitnessed falls for the completion of neurological assessments after the fall. **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** An in-service will be held by the DON/ADON/Designee with LN regarding explaining the medications a resident takes and assessment of pain prior to giving pain medications. Upon admission/insertion of residents on PICC lines will be reviewed by	2/19/17 2/19/17

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textured food from home.

During an interview with the registered dietician (RD) on 1/19/17 at 3:00 p.m., she acknowledged the resident should have pureed food as ordered by physician. The family should be instructed to follow the physician order, and should inform the staff about the food brought from home to be sure it was pureed texture. The RD said she would speak with the family.

During an interview on 1/19/17 at 10:00 a.m. with registered nurse C (RN C) who was assigned to Resident 16, she acknowledged the physician order for puree should be followed and the family should be observed when bringing food from outside.

A review on 1/20/17 of the facility's policy and procedure "Food Brought from Home" indicated the nurse assigned to the resident will account for the resident's intake of food from sources outside the facility.

3. Resident 25 was admitted to the facility with diagnoses including dementia (brain disease) and multiple rib fractures (a partial or complete break in the bone). Resident 25 sustained several falls while in the facility. The latest fall was on 10/13/16 when she sustained a fracture of the left distal clavicle (collarbone). There was no fall neurological flow sheet found in the clinical record after the fall in October 2016. Resident 25 expired on 11/19/16.

During an interview with the assistant director of nursing (ADON) on 1/19/17 at 4:00 p.m. she acknowledged the clinical record did not contain neurological monitoring for Resident 25's fall in

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the DON/designee with in 72 hours of admission, the COO for PICC line will be reviewed to ensure it includes the length. Residents who have an unwitnessed fall will be reported to the IDT for assessment; the IDT will review the chart and ensure that neurological assessments are being done according to policy. Any charts found to have missing documents, a QAPI will be developed. — 2/19/17

How the facility plans to monitor its performance to make sure that solutions are sustained:

The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved. — 2/19/17

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October 2016.

2. During a medication pass observation on 1/18/17 at 9:30 a.m., licensed vocational nurse B (LVN B) administered the routine daily medications to Resident 8. The medications included vitamins, stool softener, medication for stomach ulcer, medication for high blood pressure, eyedrops for glaucoma and pain medication. LVN B did not explain the purpose of the medications to the resident. She also did not assess the resident for pain prior to giving the pain medication.

During an interview with LVN B on 1/18/17 at 10:30 a.m., she acknowledged she should have explained the purpose of the medications to Resident 8 and should have done a pain assessment prior to administering the pain medication.

A review of the facility's undated policy on Medication Administration, indicated "...one of the seven 'rights' of medication include the resident has the right to know what medication does."

A review of Resident 20's physician order dated 12/2/16, indicated Acetaminophen 650 milligram (mg., unit of measure) per orem (P.O., orally) twice a day for pain management.

A review of the National Center For Biotechnology Information website (https://www.ncbi.nlm.nih.gov/pmc/articles), indicated "Pain assessment is critical to optimal pain management interventions."

3. A review of Resident 20's clinical record was done. It indicated Resident 20 had an

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unwitnessed fall on 6/10/16 at around 3:20 p.m. The resident was found lying on her left side, halfway under the bed. A post fall assessment was done with no reported injury. There was no documentation a post fall neurological assessment was done.

During an interview with licensed vocational nurse D (LVN D) on 1/20/17 at 11:30 a.m., she stated for an unwitnessed fall, 72 hour neurological monitoring should have been done.

During an interview with the assistant director of nursing (ADON) on 1/20/17 at 4 p.m., she validated that a 72 hour post fall neurological assessment should have been done.

A review of the facility's revised policy on Fall Management Program, dated 11/7/16, indicated "The licensed nurse will complete a Neurological Flow Sheet for an unwitnessed fall, or witnessed fall with suspected or known head injury for 72 hours following the fall incident. The neurological checks were to be performed at the frequency ordered: every 15 minutes x 1 hour; every 30 minutes x 1 hour; every hour x 4 hours then; every 4 hours x 66 hours or until the physician states it is no longer necessary of if the resident's condition is stable."

4. During a medication pass observation on 1/18/17 at 10:15 a.m., RN C administered three medications to nonsampled Resident 30 via his percutaneous endoscopic gastrostomy (PEG, placement of a tube through the abdominal wall into the stomach for nutritional support). After checking the tubing for placement and residual fluid, RN C flushed the PEG tubing with 30 milliliter (ml., liquid unit of measurement) of water

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F 281	Continued From page 29 before administering the first medication, and then flushed the tubing with 5 ml water in between medications. RN C proceeded to give a bolus feeding (intermittent formula feeding) of one can of +-formula and then flushed the tubing with 30 ml. water. A review of the physician order dated 12/23/15, for non-sampled Resident 30, indicated to "Flush 100 ml [water] before and after each feeding." During a concurrent interview with RN C, she acknowledged she should have flushed the tubing with 100 ml water as ordered. 5. Review of Resident 15's clinical record indicated she had unwitnessed falls on 8/20/16, 9/15/16, 10/22/16, 10/29/16, 12/26/16, and 1/16/17. There was no documentation of a post fall neurological assessment done on 10/22/16, 10/29/16, 12/26/16, and 1/16/17. During an interview with the director of nursing (DON) on 1/20/17 at 11:15 a.m., she stated staff did the neurologic assessment on two occasions and there were none for the other unwitnessed falls. She stated post fall neurologic assessment should be done for an unwitnessed fall. Review of the California Board of Registered Nursing website, California Business and Professions Code, Division 2, Chapter 6, Section 2725(b)(2), indicated RNs should follow the physician orders for a medication regimen necessary to implement a treatment per the physician's order.	F 281		
F 283 SS=D	483.21(c)(2)(i)-(iii) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	F 283		

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F 283	Continued From page 30 (c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the discharge summary was written and available for three sampled residents (23, 24, and 25) when Resident 23, Resident 24, and Resident 25's discharge summaries were not done. This failure may cause misunderstanding regarding important resident information during the residents' stay in the facility. Findings: 1. Resident 23's clinical record was reviewed. He was admitted on 11/9/16 with hemiplegia (weakness on one side of body), hypertension	F 283	**F283** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** The discharge summaries for residents, 23, 24, and 25 will be completed by the physician. **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:** A discharge summary log will be created, by the Medical Records and reviewed by the ADM in order to ensure discharge summaries are in compliance. **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:**	2/19/17 2/19/17

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F 283	Continued From page 31 (high blood pressure) and muscle weakness. Resident 23 was discharged on 12/7/16 and no discharge summary found in his clinical record. During an interview with medical records assistant E (MRA E), on 1/19/17 at 3:50 p.m., she stated there was no discharge summary done for Resident 23. MRA E also stated they should complete a discharge summary signed by the attending physician within 30 days of discharge. During an interview with the assistant director of nursing (ADON), on 1/19/17, at 4:10 p.m., she stated the discharge summary should be completed within 30 days after the discharge date. 2. Review of Resident 24's clinical record indicated she expired on 12/6/16. The discharge summary was not in her clinical record. During an interview with MRA E on 1/20/17 at 12:30 p.m., she confirmed there was no discharge summary on file. She stated the discharge summary should be completed within 30 days and it should be in the clinical record. 3. Resident 25 was admitted to the facility with diagnoses including dementia (brain disease) and multiple rib fractures (a partial or complete break in the bone). Resident 25 sustained several falls while in the facility. The latest fall was on 10/13/16 when she sustained a fracture of the left distal clavicle (collarbone). Resident 25 expired and discharged on 11/19/17. There was no discharge summary found in the clinical record. During an interview with the medical record director (MRD) on 1/20/17 at 2:30 p.m. she	F 283	When a resident discharges from the facility, MR's will send the discharge summary to the physician the next working day. A log will be developed to keep track of D/C summaries sent out. On a weekly basis the MR and ADM will review the log and see what discharge summaries have not been completed and returned. A phone call will be made to the physician, then a personal visit to obtain the discharge summary before the 30 day deadline. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The log will be part of the facility quarterly QA meeting and until compliance is achieved	2/19/17 2/19/17

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F 283	Continued From page 32 acknowledged there was no discharge summary for Resident 25 and she had informed the medical director about it. Review of the facility's policy and procedure "Discharge Summary Checklist" indicated a discharge summary should contain a summary of the resident's medically defined conditions and prior medical history.	F 283		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309	**F309** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 16 will be re-assessed for pain by nursing by 2/19/17 **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:** Medical records will print out a list of current Hospice residents and charts will be audited by nursing to ensure that they have pain assessments completed by 2/19/17	2/19/17 2/19/17

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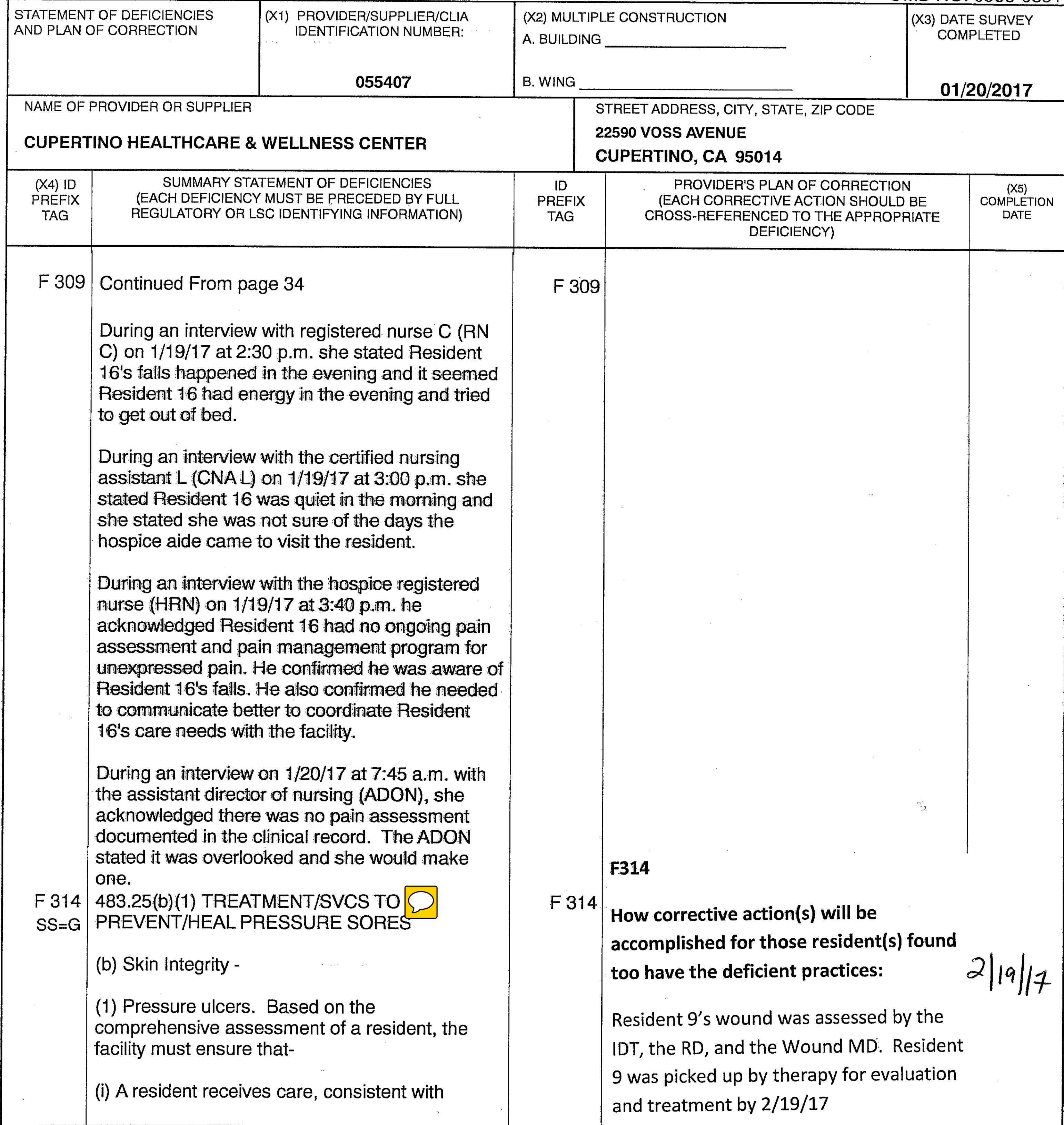
F 309	Continued From page 33 Based on observation, interview, and record review, the facility failed to ensure pain management was provided for one of 25 sampled residents (16) when there was no ongoing pain assessment performed for Resident 16 since after admission from the facility. This failure may affect Resident 16's quality of life in the facility. Findings: Resident 16 was admitted to the facility with diagnoses including Lewy body dementia (type of dementia that is related to but less known than Alzheimer's and Parkinson's diseases) and on hospice care (end-of-life care). The clinical record indicated he had falls on 1/10/17, 1/13/17, 1/15/17, and 1/18/17. Further review indicated there was no ongoing pain assessment done documented in the clinical record except upon admission. The medication administration record (MAR) indicated he received Tylenol 650 mg (pain reliever and a fever reducer used to treat many conditions such as headache, muscle aches, etc.) by mouth on 1/10/17 with a nurse's note for generalized pain. On 1/15/17 and 1/18/17 there was no documented reason why Tylenol 650 mg by mouth was given. On these dates Resident 16 also fell. During observation of Resident 16 in bed in his room the morning of 1/17/17, 1/18/17, and 1/19/17, Resident 16 intermittently responded to his name with a blank look and was nonverbal. He was relaxed in bed. His room was located away from the nurse's station and towards the corner which was not visible from the nursing station.	F 309	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** MDSC/ADON/Nursing supervisor/designee will attend morning meetings and review census to monitor hospice enrollment. When a resident enrolls in hospice the IDT will meet and ensure that a pain assessment is completed for the resident. Medical records will audit charts of residents who enroll in hospice after 72 hours of enrollment to ensure that pain assessment are done and monitor for compliance. Audits will be used to identify trends and a QAPI will be developed, if needed to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved.	2/19/17 2/19/17



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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 309	Continued From page 34 During an interview with registered nurse C (RN C) on 1/19/17 at 2:30 p.m. she stated Resident 16's falls happened in the evening and it seemed Resident 16 had energy in the evening and tried to get out of bed. During an interview with the certified nursing assistant L (CNA L) on 1/19/17 at 3:00 p.m. she stated Resident 16 was quiet in the morning and she stated she was not sure of the days the hospice aide came to visit the resident. During an interview with the hospice registered nurse (HRN) on 1/19/17 at 3:40 p.m. he acknowledged Resident 16 had no ongoing pain assessment and pain management program for unexpressed pain. He confirmed he was aware of Resident 16's falls. He also confirmed he needed to communicate better to coordinate Resident 16's care needs with the facility. During an interview on 1/20/17 at 7:45 a.m. with the assistant director of nursing (ADON), she acknowledged there was no pain assessment documented in the clinical record. The ADON stated it was overlooked and she would make one.	F 309		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 314	**F314** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 9's wound was assessed by the IDT, the RD, and the Wound MD. Resident 9 was picked up by therapy for evaluation and treatment by 2/19/17	2/19/17

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F 314	Continued From page 35 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 25 sampled residents (Resident 9) received appropriate care to prevent a pressure ulcer (skin injury caused by unrelieved pressure that results in damage to the underlying tissues). The facility failed to update Resident 9's Braden scale (a tool to predict pressure ulcer risk) and failed to implement a different kind of intervention to prevent a pressure ulcer. This failure resulted in Resident 9's left inner heel with stage II pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough). Findings: A review of Resident 9's clinical record indicated he was admitted on 9/11/16 with diagnoses including dementia (memory problem), muscle weakness and cognitive communication deficit. Resident 9's Minimum Data Set (MDS, an assessment tool) dated 10/9/16, indicated the resident had impaired cognition, required assistance with bed mobility, transfer, hygiene and bathing. The MDS also noted he was at risk for the development of a pressure ulcer. Resident	F 314	**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:** An in-service will be held by the DSD/designee with LN's and CNA's regarding reporting of COC and reporting, example from this 2567 will be used during the in-service by 2/19/17 A treatment nurse has been hired by the facility. Quarterly skin sweeps will be performed by the nursing staff to assist in identifying any new skin issues by 2/19/17	2/18/17

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F 314	Continued From page 36 9's MDS for 12/2016 was not completed. During an interview with the MDS coordinator (MDSC) on 1/17/17 at 1:40 p.m., she stated Resident 9's quarterly assessment was scheduled on 12/15/16 and it was not completed A review of Resident 9's admission assessment dated 9/11/16 indicated under skin integrity, he had skin discoloration on the left hand and left forearm, multiple skin rashes on the right and left forearms, and skin redness on the resident's buttocks. Resident 9 had no pressure ulcer on the left inner heel upon admission. A review of Resident 9's Braden scale dated 9/11/16, indicated he was at mild risk for developing a pressure ulcer. Resident 9's Braden Scale for 12/2016 was not updated. A review of Resident 9's skin care plan dated 9/11/16, indicated the resident was at risk for a pressure ulcer related to impaired mobility, cognitive impairment, and fragile skin. The interventions to prevent pressure ulcer included repositioning with care rounds and referral to the registered dietitian (RD) if needed. A review of Resident 9's weekly pressure ulcer progress report dated 1/9/17, indicated he had developed a blister (it was raised on the skin which contains clear liquid and that was caused by injury or rubbing against something) on his left inner heel, which measured approximately three centimetera (cm, unit in measurement) length and three cm in length. The interventions for preventing pressure ulcer were floating heel (the heels were off the bed) and heel protector.	F 314	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** Facility will implement a system for notification of change of condition (stop and watch) The stop and watch forms will be brought to morning meeting DSD/designee will receive the forms and verify that the information on the forms has been communicated and that the needed follow up has been done The IDT meet to discuss and review any new pressure ulcer issues, intervention will be developed and implemented. A log of the forms will be kept and reviewed by the DSD/designee for trends and compliance	2/19/17

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F 314	Continued From page 37 During an observations on 1/17/17 at 3 p.m., 1/18/17 at 3:35 p.m., and 1/19/17 at 8:00 a.m., Resident 9 was lying on his back and his left inner heel rested on his bed with no heel protector. During an interview with licensed vocational nurse A (LVN A) on 1/18/17, at 3:30 p.m., she stated she was the assigned charge nurse when Resident 9 developed a blister on his left heel with stage II pressure ulcer on 1/9/17. LVN A stated Resident 9 was always in bed and got his blister from his bed. During an observation and interview with licensed vocational nurse B (LVN B) on 1/18/17, at 3:35 p.m., she confirmed Resident 9 was lying on his back. The left inner heel pressure ulcer rested on the bed with yellowish color around the dressing, and Resident 9's bed linen had yellow circle color drainage from his left inner heel pressure ulcer. She stated Resident 9 should have been repositioned and the left inner heel stage II pressure ulcer should have been floating when he was in bed. During an interview and record review with the assistant director of nursing (ADON) on 1/18/17, at 3:45 p.m., she stated she was not aware of Resident 9's left inner heel pressure ulcer. She stated Resident 9 developed his left inner heel stage II pressure ulcer from his bed and nursing staff should have repositioned Resident 9 when he was in bed. The ADON confirmed Resident 9 was a high risk for developing a pressure ulcer. He was immobile, and it was an avoidable pressure ulcer. She also stated there was no interdisciplinary (IDT, team members from different departments involved in a resident's care) notes, the Braden scale was not updated,	F 314	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The log developed by the DSD will reviewed by the ADM and/or DON, any trends identified will be used to develop a QAPI. The QAPI will be part of the facility quarterly QA process and until complaicne is achevied.	2/19/17

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F 314	Continued From page 38 and there was no RD referral. During wound care observation and interview with treatment nurse I (TN I) on 1/18/17, at 8:50 a.m., Resident 9's left inner heel pressure ulcer was observed with slough and dry black blood in the wound bed area. TN I stated Resident 9's left inner heel pressure ulcer had increased in size, and measured approximately 5.5 cm in length and 4.8 cm in width. TN I confirmed Resident 9 had no heel protector and he should have it. A review of the facility's policy titled, "Pressure Injury Prevention" dated 8/12/16, indicated to provide interventions for residents identified as high risk for developing a pressure ulcer. A risk assessment (Braden Scale) for a developing pressure ulcer will be completed in a timely manner. The nursing staff will implement interventions identified in the care plan based on individual risk factors. Nursing staff will observe for any signs of potential or active pressure injury daily while providing nursing care.	F 314		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323	**F323** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 19 will be re-assessed by the IDT by 2/19/17	2/19/17

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F 323	Continued From page 39 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate assistance to prevent accident and injuries for one of 25 sampled residents (Resident 19). The facility failed to assist the resident to the bedside commode, and failed to implement a different kind of intervention in response to Resident 19's frequent falls. These failures resulted in Resident 19 sustaining a bump on the left side of her eye and a left clavicle fracture. Findings: Review of Resident 19's clinical record indicated the resident was admitted on 9/23/11 with diagnoses including hepatic failure (liver failure), convulsions (seizure) and dementia (memory problem). Her minimum data set (MDS, an assessment tool) dated 7/6/16, indicated the resident had impaired cognition (mental process), required assistance for bed mobility, transfer, and toileting. There were no MDS's in 10/2016 and 1/2017.	F 323	**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:** An in-service will be given to the LN/IDT by the DSD/designee regarding fall prevention; the issues in this 2567 will be used as examples The DON/Designee will log all falls in the incident log The IDT will review all reported falls and develop plans of care to assist in reducing future falls **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The incident log will be reviewed by the DON and/or ADM monthly to track and identify any trends Any trends identified will be used by the facility to provide training and education	2/19/17 2/19/17

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F 323	Continued From page 40 Review of Resident 19's Fall Risk Assessment dated 9/19/16, indicated she had a score of 14. A score of 10 or above represents a high risk for falls. Review of Resident 19's Fall Risk Prevention and Management care plan dated 5/19/16, indicated Resident 19 had a risk for fall related to her history of falls and unsteady gait (abnormal walking). The interventions to prevent falls included placing the call light within reach, remind the resident to use the call light, provide an environment which minimized hazards over which the facility has control, and encourage the use of a front wheel walker. Review of Resident 19's cognitive loss care plan dated 5/19/16, indicated Resident 19 had a period of forgetfulness, short term memory loss and poor judgment. Review of Resident 19's situation background assessment recommendation (SBAR, a technique used to facilitate prompt and appropriate communication) dated 9/19/16, indicated the resident had an unwitnessed fall when she was found on the floor next to her bed. This resulted in a skin tear on the back of the head and a skin tear on her right hand. Review of Resident 19's post fall short term care plan dated 9/19/16, indicated the incident occurred when Resident 19 wanted to use the bedside commode. The intervention to prevent falls was to place the resident on bladder assistance (assist to the bathroom) every two to three hours. There was no evidence Resident 19 was placed on bladder assistance every two to three hours.	F 323	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The trending and tracking will be used to develop a QAPI. The QAPI will be part of the facility quarterly QA process and until compliance is achieved.	2/19/17

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F 323	Continued From page 41 Review of Resident 19's bowel and bladder assessment and interventions dated 7/6/16, indicated the resident would proceed with a retraining program. There was no bowel and bladder assessment in 10/2016. Review of Resident 19's post fall interdisciplinary (team members from different department involved in a resident's care) assessment dated 9/19/16, indicated the resident lost her balance during transfer. The intervention to prevent falls was to remind the resident to use the call light for needs, and encourage her to move slowly when changing position. Review of Resident 19's SBAR dated 10/22/16, indicated the resident had an unwitnessed fall when the resident used the bedside commode, lost her balance and fell. Resident 19 complained of pain, dizziness, a lump was noted on the back of the head, and the resident was sent to an acute hospital. Review of Resident 19's Fall Risk Assessment dated 10/22/16, indicated she had a score of 14. A score of 10 or above represents a high risk for falls. Review of Resident 19's acute hospital diagnosis dated 10/22/16, indicated the resident had a diagnosis of a hematoma (a collection of blood outside of blood vessels) of the scalp. Review of Resident 19's post fall interdisciplinary assessment dated 10/24/16, indicated the resident tried to use the bedside commode, lost her balance and fell. The intervention to prevent a fall included to monitor orthostatic hypotension	F 323		

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F 323	Continued From page 42 (decrease in blood pressure) upon return from the acute hospital. There was no evidence the resident was monitored for orthostatic hypotension. Review of Resident 19's SBAR dated 10/25/16, indicated the resident had an unwitnessed fall. When the resident fell, the resident complained of dizziness, and a bump on the left side of her left eye. The resident was sent to an acute hospital. Resident 19's acute hospital diagnosis dated 10/25/16 indicated the resident had a left clavicle fracture. Review of Resident 19's post fall interdisciplinary assessment dated 10/24/16, indicated the resident got up from bed, forgot to use the call light, tried to use her bedside commode but lost her balance and fell. The intervention to prevent a fall included to remind the resident with each contact to call for assistance, educate regarding the risk, and consequence of doing an independent transfer. Review of Resident 19's SBAR dated 1/9/17, indicated the resident had an unwitnessed fall when she was found sitting on the floor with a right shin (lower extremities) abrasion (scrape). Review of Resident 19's post fall interdisciplinary assessment dated 1/9/17, indicated the resident rolled off the edge of the bed. The intervention to prevent a fall was to put a floor mat at the resident's bedside. Review of Resident 19's Fall Risk Prevention and Management care plan dated 11/30/16, indicated Resident 19 had a risk for fall related to history of falls, decreased endurance and medications,	F 323		

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F 323	Continued From page 43 e.g., Propranolol (blood pressure medication), Dilantin (for seizure), and Melatonin (medication to control the sleep and wake cycle). During an observation and interview with licensed vocational nurse J (LVN J) on 1/20/17 at 8:05 a.m., Resident 9 was lying on her bed, with the bedside commode nearby. The call light was bent to the other side of the bedside table. LVN J confirmed Resident 19's call light was not within reach and she could not call for assistance. LVN J also stated Resident 19 had no floor mat. During an interview with the director of nursing (DON) on 1/20/17 at 2:35 p.m., she stated Resident 19 was a high risk for falls related to her confusion and forgetfulness. The resident required assistance for transfer and toileting. The DON stated the interventions should have been implemented and new interventions should have been developed to prevent falls. She also stated Resident 19 should have been referred to therapy related to her frequent falls. The DON acknowledged there was no bowel and bladder training every two to three hours, there was no weekly summary from 9/21/16 to 10/26/16, no monitoring for orthostatic hypotension, no floor mat and the call light should have been within reach. Review of the facility's 11/7/2016 policy, "Fall Management Program," indicated the facility will implement a fall management program which supports and provide an environment free from hazards. The licensed nurse and interdisciplinary team (IDT, team members from different department involved in a resident's care) will develop a plan of care according to the identified risk factors and root cause. The licensed nurse	F 323		

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F 323	Continued From page 44 will evaluate the resident's response to the plan of care during weekly summary evaluation and will update the care plan as necessary.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to monitor the effectiveness and possible side effects of medications for two of 25 sampled residents (4 and 12). For Resident 4, lipid panel and liver function test (LFT) were not monitored while he was on Lipitor (cholesterol lowering agent). For Resident 12, there was no specific behavior monitoring while on quentiapine (antipsychotic medication). These failures placed the residents at an increased risk for side effects	F 329	**F329** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Nursing will ensure that Residents 4 lab will be done by 2/19/17 Resident 12 will have the behavior monitoring updated by nursing by 2/15/17 **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:** Medical records will provide a list of residents who have lab orders related to the use of Lipitor and residents on quentiapine to the ADON. DON will review these residents will have labs done a	2/19/17 2/19/17

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F 329	Continued From page 45 from unnecessary medications. Findings: 1. Resident 4's clinical record was reviewed and indicated he was admitted on 7/29/16 with diagnoses including anemia, bipolar disorder, chronic kidney stage, and chronic obstructive pulmonary disease. There was a physician order, dated 7/29/16, to give lipitor 20 mg daily for hyperlipidemia. Review of laboratory results showed no evidence of lipid panel and liver function tests were monitored. During an interview with licensed vocational nurse G (LVN G), on 1/17/17 at 3:20 p.m., she stated she could not find any lipid panel and LFT since admission in Resident 4's clinical record and would ask the medical records department. During an interview with medical records assistant F, on 1/17/17 at 3:20 p.m., she stated she could not find any lipid panel and LFT laboratory results for Resident 4. During an interview with the assistant director of nursing (ADON) on 1/18/17, at 9:15 a.m., she stated they usually monitor lipid panel and LFT for residents on Lipitor every 6 months. A review of the facility's 2017 Davis Drug Handbook with the ADON, indicated lipid panel and LFT will be checked at initiation, 6 weeks, and 12 weeks after initiation and periodically to monitor effectiveness and possible side effects of Lipitor. 2. Review of Resident 12's clinical record indicated she was admitted on 12/28/16 with a	F 329	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The nursing supervisor will get a monthly list of the residents who fall into these two above mentioned categories and audit their charts to ensure compliance. DON/ADON will review residents with order for Lipitor for lab during their admission during stand up meeting. The results of the audit will be used to develop a QAPI, if needed. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved.	2/19/17 2/19/17

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F 329	Continued From page 46 diagnosis of psychosis (mental disorder). Her MDS dated 1/4/17, indicated the resident was cognitively intact. Review of Resident 12's physician order dated 12/28/16, indicated an order of quentiapine 50 milligrams (mg, unit of measurement) one tablet once a day for psychosis. During an interview with registered nurse C (RNC) on 1/18/17 at 12:20 p.m., she stated Resident 12 was taking quentiapine 50 mg once daily for psychosis but there was no specific behavior monitoring. She also stated she was not sure what specific behavior Resident 12 manifested. During an interview with the ADON on 1/18/17 at 12:30 p.m., she stated there should have been specific behavior monitoring associated with the use of quentiapine to check whether the medication was effective for the resident. She stated the specific behavior monitoring should have been written on the medication administration record but she was unable to find it. Review of the facility's policy 5/2016, "Behavior/Psychotropic Drug Management" indicated any order for psychotropic medications must include specific behavior. The information will assist the licensed nurse and interdisciplinary members in evaluating the appropriateness of the medication dosage.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure	F 332		

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F 332	Continued From page 47 that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility had a 9.6% medication error rate when three medication errors out of 31 opportunities were observed during medication passes for one sampled resident (8) and 2 nonsampled residents (26 and 30). These failures had the potential to compromise residents' medical health. Findings: 1. During a medication pass observation on 1/18/17 at 8 a.m., registered nurse C handed a Qvar inhaler (steroid medication to treat asthma) to Resident 26 . The resident placed the inhaler in his mouth, inhaled deeply, administered one puff and held his breath around eight seconds then administered the second puff. After the inhalation, the resident handed the inhaler back to RN C. There were no instructions given to the resident regarding time interval between puffs and to rinse his mouth (and spit) after the inhalation. During an interview with RN C on 1/18/17 at 8:40 a.m., she acknowledged she should have instructed Resident 26 on properly using the inhaler. Review of the physician's order dated 1/7/17 indicated, "Qvar 80 mcg. (unit of measure) inhale two inhalations by mouth twice a day." Review of the manufacturer's specifications	F 332	**F332** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 26 and 8 will be re-assessed by nursing regarding inhaler and eye drops by 2/19/17 LN's who were followed during survey will be in-serviced by the DON on proper administration of inhalers, eye drops, and missing medications by 2/19/17 **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:** LN's will be in-serviced by the DON/DSD/Designee regarding proper administration of inhalers, eye drops and missing medications by 2/19/17	2/19/17 2/19/17

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F 332	Continued From page 48 indicated to rinse mouth and throat (and spit) after use to prevent Candida infection. 2. During a mediation pass observation on 1/18/17 at 9:30 a.m., licensed vocational nurse B (LVN B) administered two medicated eyedrops to Resident 8's right eye. Dorzolamide 2% (to treat glaucoma, a condition that increases fluid pressure in the eye) one drop to right eye, and Brimonidine 0.2% (to treat glaucoma). The eyedrops were administered one after the other, without an adequate interval of time between eyedrops. During a telephone interview with LVN C on 1/19/17 at 10 a.m., she stated if two different eyedrops were administered, she should have waited one to two minutes between administering the eyedrop medications. 3. During a medication reconciliation review on 1/18/17 at 10:30 a.m., Resident 8's daily medications included Amlodipine (medication to treat high blood pressure) 10 milligrams (mg, a unit of measure) orally daily for high blood pressure. The medication was missed during the medication pass. However, the medication administration record (MAR) indicated it was signed by LVN C as given. During a concurrent interview with LVN B, she confirmed she missed the medication but signed it as given. Review of the California Board of Registered Nursing website, California Business and Professions Code, Division 2, Chapter 6, Section 2725(b)(2), indicated RNs should follow the physician orders for a medication regimen	F 332	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The DON/designee will conduct medication pass review with 1 LN a week, for 3 months, and then each LN will have annual medication pass skills checks to ensure compliance. The facility will ask the contracted pharmacy to have their nurse come and conduct some of the above mentioned medication pass reviews, to monitor for compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained:** Results of the reviews will become part of the facility quarterly QA meeting and until compliance is obtained.	2/19/17 2/19/17

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F 332	Continued From page 49 necessary to implement a treatment per the physician's order. According to Lexicomp, an online nationwide source for drug information, the manufacturer specifications for both eyedrop medications indicated, "if more than one ophthalmic drug is being used, administer the drugs at least 5 minutes apart."	F 332		
F 363 SS=D	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 363	**F363** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** In-service will be done by the DM/designee with cook P regarding proper preparation of puree food by 2/19/17 **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:** An in-service will be done by the DM/designee with the facility cooks regarding the proper technique for pureed food by 2/19/17.	2/19/17 2/19/17

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F 363	Continued From page 50 by: Based on observation, interview, and record review, the facility failed to ensure the written puree recipe was followed for 17 residents on pureed diets. This failure may affect the nutritional needs of the residents. Findings: During observation of the puree food preparation on 1/18/17 at 8:55 a.m. with dietary cook P (DC P) he prepared the puree for 17 residents by mixing water with green peas and cauliflower. During an interview with the dietary manager (DM) she stated the facility uses chicken broth and not water. Review on 1/19/17 of the facility's policy and procedure "Recipe: Pureed Vegetables" indicated no use of water in the menu.	F 363	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The dietary manager will observe the preparation on the puree foods 3 times a week for 30 days to ensure that it's being prepared correctly. A log will be kept. The log will be used to develop a QAPI, is needed. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved	2/19/17 2/19/17
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide food and drink that was palatable, attractive, and at a safe and	F 364	**F364** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Residents 2, 11, 13, 15, 18, 19, 21, 32, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, and 46 will be interviewed by the dietary manager/designee regarding any food concerns by 2/19/17	2/19/17

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F 364	Continued From page 51 appetizing temperature for seven sampled residents (2, 11, 13, 15, 18, 19, and 21) and 13 nonsampled residents (32, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, and 46). This failure could affect the dining experience of the residents. Findings: 1. During the initial tour of the facility on 1/17/17 at 8:00 a.m., Resident 2's tray was still at the bedside table and untouched. Resident 2 stated he did not like his food, and it was okay to miss his breakfast. During Resident 2's interview on 1/17/17 at 1:00 p.m., he stated the facility's food was terrible and he sometimes ordered outside food. Resident 2 stated the food had no taste and oftentimes was cold. Resident 2 also said the kitchen always served eggs for breakfast. During an interview with Resident 2 in his room on 1/18/17 at 8:30 a.m., he stated he did not like his breakfast and returned it. Resident 2 stated he ate a sandwich instead. During an interview with the dietary manager (DM) on 1/18/17 at 11:15 a.m. she stated several times she had discussed with Resident 2 his diet. The DM stated Resident 2 often changed his food choices. 2. During an initial tour on 1/17/17 at 8 a.m., Resident 30 was awake and waiting for her breakfast tray. She stated, "the food here is terrible," usually served "cold" and did not taste good. During an interview on 1/18/17 at 11:40 a.m. in	F 364	**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:** The facility will start a food committee and the above mentioned residents will be asked to participate in the meeting. This is an on-going program that will remain in place, to try and address any food related issues. The DM/designee will conduct test tray audits for one breakfast, one lunch, and one dinner shift per week, for a period of 30 days, then quarterly after that, then annually. **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** Minutes from the food committee will be kept and reviewed by the ADM and/or RD. QAPI will be developed, if needed. This is an on-going process in order to minimize issues, but may not eliminate issues all together.	2/19/17 2/19/17

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F 364	Continued From page 52 Resident 30's room, she stated the facility's food taste and texture was "rotten" and tasted "old." She stated she made her concerns known to kitchen staff and there was no change. The resident also stated she mentioned her concerns regarding food during Resident Council Meetings. 3. During an initial tour on 1/17/17 at 7:30 a.m., Resident 32 was observed eating his breakfast. He stated the "food was sloppy" and the cereals cold and watery. Resident 33 stated the taste of the food "was horrible." Resident 44 stated several times the food served at lunch was cold. Resident 19 stated the taste of the food was bad, and several times was served cold. Resident 21 stated the dinner was served cold. Resident 45 stated the taste of the food was bad and it was always served cold. Resident 36 stated the food had no flavor and was served cold anytime of the day. During interview with Resident 11 on 1/17/17 at 3:10 p.m., she stated the food was served cold most of the time and that she had voiced her concerns to the staff. During a resident group meeting on 1/18/17 at 10 a.m. Resident 21, Resident 37, Resident 38, Resident 40, Resident 41, and Resident 46 stated their food was served cold. Resident 37, Resident 38, Resident 40, and Resident 46 stated the food had no taste. Resident 21 and Resident 37 stated they asked staff to warm their food and staff told them the microwave was broken. During an interview on 1/18/17 at 9 a.m., Resident 15 stated the taste of the food was not good and her breakfast coffee was always served cold.	F 364	**How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will become part of the facility quarterly QA meeting and until compliance is achieved	2/19/17

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F 364	Continued From page 53 During lunch observation on 1/19/17 at 1 p.m., Resident 42 did not eat his lunch. Resident 42 stated the appearance of the food was not appealing. He stated the facility's food tasted bad and it was always served cold. During lunch observation on 1/20/17 at 12:40 p.m., Resident 43 was in the hallway showing his bowl of gelatin. He stated it was watery and he did not like it. During an interview with Resident 18 on 1/20/16, she stated she did not like the taste of her food and she had to ask her family member to bring her food. During an interview with the dietary manager (DM) on 1/19/2017 at 8:30 a.m., she stated she had discussed with several residents their food preferences and food concerns. Food should taste "good" for the residents and should be served warm. A review of the facility's undated policy "Food Preparation" indicated "food shall be prepared by methods that conserve nutritive value, flavor and appearance."	F 364		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371	**F371** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:**	2/19/17

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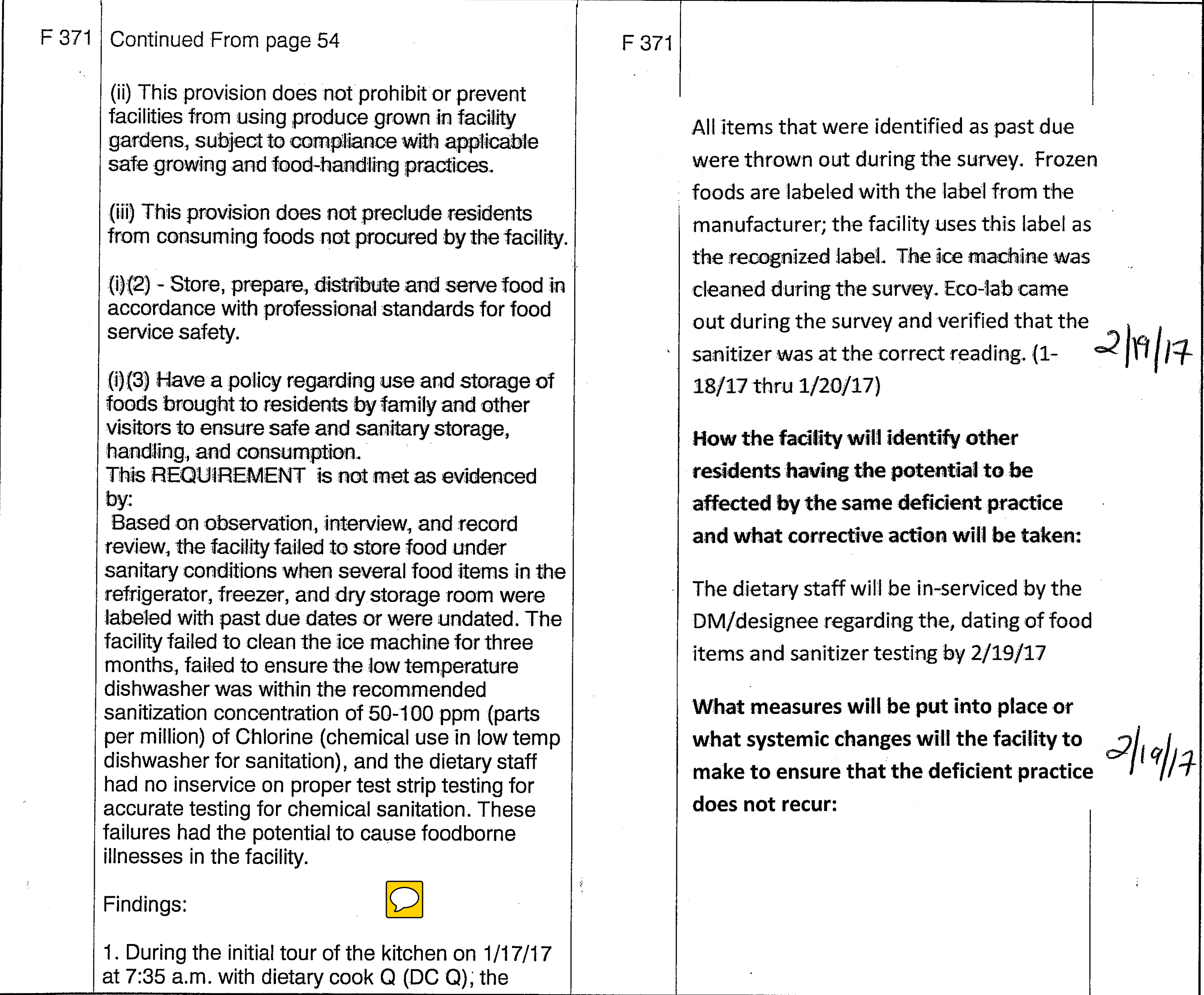

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F 371	Continued From page 54 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store food under sanitary conditions when several food items in the refrigerator, freezer, and dry storage room were labeled with past due dates or were undated. The facility failed to clean the ice machine for three months, failed to ensure the low temperature dishwasher was within the recommended sanitization concentration of 50-100 ppm (parts per million) of Chlorine (chemical use in low temp dishwasher for sanitation), and the dietary staff had no inservice on proper test strip testing for accurate testing for chemical sanitation. These failures had the potential to cause foodborne illnesses in the facility. Findings: 1. During the initial tour of the kitchen on 1/17/17 at 7:35 a.m. with dietary cook Q (DC Q), the	F 371	All items that were identified as past due were thrown out during the survey. Frozen foods are labeled with the label from the manufacturer; the facility uses this label as the recognized label. The ice machine was cleaned during the survey. Eco-lab came out during the survey and verified that the sanitizer was at the correct reading. (1-18/17 thru 1/20/17) **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:** The dietary staff will be in-serviced by the DM/designee regarding the, dating of food items and sanitizer testing by 2/19/17 **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:**	2/19/17 2/19/17

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F 371	Continued From page 55 following food items in the refrigerator had written past due dates or were undated: a. cooked chicken - 1/16/17 b. a tray of dessert - 1/16/17 c. pork sausage in a tray pan - 1/13/17 d. fruit juice in a pitcher - 1/11/17 e. apple juice in a pitcher - 1/14/16 f. pudding bowl - 1/15/16 g. a tray of gelatin - 1/13/17 h. three full trays of dessert undated All frozen foods in the walk in freezer were not dated, except for a box of strawberry topping. The dry storage room had one shelf with undated cans. The other boxes of canned foods had two dates but this was not consistent on all the food items. During a concurrent interview with the DC Q, he acknowledged most of the food items were not dated and some had the wrong year or were past dated. DC Q stated the staff used to write the "use by date" and he emphasized dating the foods to staff. Review on 1/19/17 of the facility's policy and procedure "Food Receiving and Storage" indicated all foods stored in the refrigerator or freezer would be covered, labeled, and dated. Dry foods stored in bins will be removed from the original packaging, labeled, and dated. 2. During an observation of the ice machine and interview with the assistant maintenance (AM) on 1/18/17 at 2:00 p.m., the AM had the ice machine maintenance log which indicated the ice machine was not cleaned for the months of September, October, and November 2016. The AM stated he	F 371	The dietary manager/designee will check the refrigerators three times a week to ensure that the food is labeled properly. A log of the checks will be kept. The DM/designee will randomly audit (3 times a week) the chemical test strip testing to ensure compliance and a log will be kept by the DM/designee. The maintenance department will clean the ice machine monthly and a log will be made, the logs will be audited by the ADM quarterly to ensure compliance. If a trend of errors occurs in the above audits a QAPI will be develop. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved.	2/14/17

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F 371	Continued From page 56 was hired in December 2016 and cleaned the ice machine. The AM acknowledged the ice machine should be cleaned monthly per the manufacturer's recommendation. Review on 1/18/17 of the facility's policy and procedure "Ice Machine-Operation and Cleaning" indicated the ice machine would be cleaned routinely and according to the manufacturer's recommendation. 3. During observation of the low temperature chemical dishwasher on 1/17/17 at 3:25 p.m. with dietary aide R (DA R), she dipped the test strip longer than one second to get the recommended color of the test strip. The strip color was below the recommended reading 50 ppm. The test was repeated two more times with the same result. A concurrent interview with the dietary manager (DM) was conducted. DM stated she would contact the ECOlab (a company which offers water, hygiene, and energy technologies and services that provide and protect clean water, safe food, abundant energy, and healthy environments for food) right away to check the machine. Review of the facility's policy and procedure "Dish Machine Temperature Recording" indicated the concentration of the sanitary solution during rinse cycle should be 50 ppm for chlorine sanitizer. 4. During observation of the low temperature chemical dishwasher on 1/17/17 at 3:35 p.m. with DA R, DA R dipped the test strip longer than one second to obtain the desired strip color. The test strip literature was reviewed at the same	F 371		

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F 371	Continued From page 57 time which indicated the test time was one second to get the correct strength of the solution in parts per million (ppm) available chlorine. During a concurrent interview with DA R and DC Q, they acknowledged they needed an inservice on the proper test strip testing to obtain an accurate test strip result. They were aware the kitchen was using two chemical sanitizing solutions, the chlorine for the low temp and the quaternary for the red buckets sanitizing the kitchen counters and tables.	F 371	**F372** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** The dumpster area was cleaned during survey (1/19/17)	2/19/17
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure garbage was properly disposed when there was garbage scattered around the Dumpster. This practice had the potential to attract vermin and pests. Findings: During an environmental tour with the director of maintenance (DM) and the assistant maintenance (AM) on 1/17/17 at 2 p.m., the garbage area at the back of the facility was observed to have papers, plastic spoons, disposable aprons and plastic waste scattered around the Dumpster. During a concurrent interview with the DM, he confirmed the above observation. He stated garbage should be properly contained in the Dumpster and not scattered on the ground.	F 372	**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:** The janitors will clean the dumpster area before they leave at night, when they arrive in the am and after 10am (allowed time for the dump truck) by 2/19/17 **What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** The housekeeping supervisor will do rounds daily to ensure that the dumpster area is being cleaned according to the above times. The ADM will do rounds three times a week, to ensure dumpster area is cleaned at appropriate times. ADM will keep a log of times dumpster was checked.	2/19/17

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F 372	Continued From page 58 Review of the facility's undated policy "Environmental Waste," indicated the facility would ensure trash and environmental waste was disposed properly.	F 372	**How the facility plans to monitor its performance to make sure that solutions are sustained:** This log will be part of the facilities quarterly QA meeting and until compliance is achieved	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441	**F441** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** The O2 tubing and the urinal were labeled during the survey (1/20/17) **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:** The DSD/Designee will in-service the CNA's regarding the proper labeling of urinals by 2/19/17. The DSD/DON/designee will in-service the LN's regarding the proper labeling of O2 tubing by 2/19/17.	2/19/17

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F 441	Continued From page 59 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an infection control prevention and control program was in place when Resident 16's oxygen tubing was undated, and the urinal for Resident 35 was not	F 441	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** During the weekly rounds the DSD/Department heads will check the labeling of urinals and dating of O2 tubing, and notify the LN of the items requiring correction. During morning meeting it will be reported which rooms had unlabeled O2 or urinals. The DSD will keep track of any trends and develop a QAPI if needed. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is achieved.	2/19/17

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F 441	Continued From page 60	F 441		

labeled. These practices had the potential to spread infection within the facility.

Findings:

1. During the initial facility tour on 1/17/17 at 8:00 a.m., Resident 16 was in bed and at the bedside was an oxygen (O2) tank connected to an O2 nasal cannula (a device used to deliver supplemental O2) in a plastic bag. The O2 tubing was not dated as to when it was changed.

During a review of Resident 16's clinical record on 1/17/17 at 3:00 p.m. he was prescribed O2 at two liters per nasal cannula as needed for shortness of breath.

During an interview with licensed vocational nurse S (LVN S) on 1/19/17 at 8:20 a.m. she stated the staff did not date the tubing because the resident had not used the O2 tubing.

During an interview on 1/19/17 at 2:45 p.m. with the director of staff development/infection control (DSD/IC), she stated O2 tubing should be dated once the staff connected it to the tank/concentrator even it was not used by the resident.

Review on 1/20/17 of the facility's policy and procedure "Oxygen Therapy" indicated to change the oxygen tubing, mask, and cannulas no less than seven days and as needed.

2. During the initial tour of the facility and interview with Resident 35 on 1/17/17 at 8:00 a.m., Resident 35 's urinal was unlabeled. Resident 35 voiced out "my urinal was not labeled. The staff did not label it."

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F 441	Continued From page 61 During a concurrent interview with certified nursing assistant S (CNA S) she acknowledged the urinal was not labeled and it should have been labeled. Review of the facility's policy and procedure on 1/120/17 "Resident Rights - Personal Property" indicated residents are to retain personal possessions and clothing at the facility.	F 441		
F 505 SS=D	483.50(a)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS (a) Laboratory Services (2) The facility must- (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to notify the physician of abnormal laboratory results for one of 25 sampled residents (21). This practice could delay the appropriate treatment the resident needed. Findings: Resident 21's clinical record was reviewed and indicated she was readmitted on 11/19/16, with COPD (Chronic Obstructive Pulmonary Disease, a chronic respiratory disorder), diabetes mellitus,	F 505	**F505** **How corrective action(s) will be accomplished for those resident(s) found too have the deficient practices:** Resident 21's physician will be notified by nursing of the abnormal potassium level by 2/19/17 **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:** Medical Records will provide a list of all residents with an order for potassium level to the DON/designee by 2/15/17. DON/ADON/designee will review the list ensure that abnormal levels are reported to the physician.	2/19/17 2/19/17

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F 505	Continued From page 62 and muscle weakness. A laboratory result dated 12/16/16, indicated an abnormal level of potassium (major electrolyte which is necessary for the function of all living cells) of 5.8 mEq/L (unit of measurement). Review of the facility's clinical reference value indicated the normal range of potassium level was between 3.5-5.1 mEq/L. During a concurrent interview with the assistant director of nursing (ADON), on 1/20/17 at 8:20 a.m., she stated the physician should have been notified of the high level of potassium. The ADON stated it was the licensed nurse's responsibility to notify the physician of any abnormal laboratory results. Review of facility's "Change of Condition Notification" policy, dated 4/1/15, indicated "a licensed nurse will notify the resident's attending physician of routine laboratory and diagnostic results as soon as possible after received". It also indicated to document notification on the reports and progress notes.	F 505	**What measures will be put into place or what systemic changes will the facility to make to ensure that the deficient practice does not recur:** DON/ADON/Designee will review the labs for the residents on potassium on a monthly basis for one quarter. Any trends for not reporting abnormal levels will be identified by the DON and a QAPI will be developed. **How the facility plans to monitor its performance to make sure that solutions are sustained:** The QAPI will be part of the facility quarterly QA meeting and until compliance is obtained.	2/19/17

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