STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	09/13/2016

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflect the findings of the California Department of Public Health during a Re-certification Survey conducted from 9/6/16 to 9/13/16. The census at the time of the survey was 750 residents with seven bed holds. The total sample was 43 residents which included 13 random residents. The highest scope and severity was E. Representing the California Department of Public Health: Surveyor 31794, Health Facilities Evaluator Nurse Surveyor 21223, Health Facilities Evaluator Manager 1 Surveyor 31922, Health Facilites Evaluator Nurse, acting Supervisor Surveyor 35790, Health Facilities Evaluator Nurse Surveyor 36814, Health Facilities Evaluator Nurse Surveyor 36966, Health Facilities Evaluator Nurse Surveyor 37635, Health Facilities Evaluator Nurse Surveyor 37653, Health Facilities Evaluator Nurse	F 000	This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("Laguna Honda" or "facility") as required by regulation, to the Statement of Deficiencies (Form CMS-2567) issued by the California Department of Public Health on October 3, 2016, and received by the facility on October 4, 2016, during a Re-certification survey which began on September 6, 2016 and concluded on September 13, 2016. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed on the CMS Form 2567 Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the	F 156	The facility has implemented policies and procedures to provide written information to residents and/or their surrogate decision makers concerning their right to formulate an advance directive. Social Workers have met or contacted the resident's surrogate decision-makers and provided them with information on Advance Directives.	

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

Executive Administrator 10/14/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment	F 156	1 a. Resident 2's Resident Social History Assessment was updated to reflect that Advance Directive information was provided to the resident. 1 b. Resident 5's Resident Social History Assessment was updated to reflect that Advance Directive information was sent to the Resident 5's brother and newly appointed probate conservator. 1 c. Resident 11's Resident Social History Assessment was updated to reflect that Advance Directive information was reviewed and provided to her daughter. 1 d. Resident 15's Resident Social History Assessment was updated to reflect that Advance Directive information was reviewed and provided to his sister. 1 e. Resident 19's Resident Social History Assessment was updated to reflect that Advance Directive information was provided to the resident. 1 f. Resident #22's Resident Social History Assessment was updated to reflect that Advance Directive information was reviewed and given to the resident and Resident 22's brother who is the resident's representative. 1 g. Resident #26's Resident Social History Assessment was updated to reflect that Advance Directive information had been mailed to Resident 26's daughter. 1 h. Resident 30 is no longer a resident at the facility. Resident 30 was discharged on 6/19/16.	9/22/16 10/13/16 10/13/16 9/22/16 9/23/16 9/21/16 9/22/16

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F 156	Continued From page 2 toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1) Provide written information to residents and/or their surrogate decision makers concerning the right to formulate an advance directive for nine of	F 156	1 i. Resident 8's Resident Social History Assessment was updated to reflect that Advance Directive information was provided to resident's mother who is the surrogate decision-maker for the resident. The Resident Social History Assessment of other residents were reviewed by respective Social Workers on their assigned neighborhoods for completeness and verification that there is documentation that residents and/or surrogatedecision-makers were provided with information on Advance Directives. The medical records of these residents were updated as necessary to indicate the current state of their Advance Directives. Social Workers are responsible for documentation review and follow-up actions as necessary. The Director of Social Services is responsible for monitoring compliance. Social Services staff were provided an in-service by the Director of Social Services who reviewed the facility's policy and procedure on Advance Care Planning and the areas of the Resident Social History Assessment that require to be documented, including the need for additional explanation to reflect the status of advance directive material provided to residents and or surrogate decision-makers when appropriate to meet federal requirements. Director of Social Services is responsible for monitoring compliance that Social Workers receive and review the in-service material.	9/26/16 10/13/16 10/13/16

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F 156	Continued From page 3 43 sample residents (Resident 2, 5, 11, 15, 19, 22, 26, 30 and Resident 8). Failure to provide written information regarding advance directive did not ensure these residents and/or their responsible parties were able to make an informed decision regarding advance directives. 2) Post the State required signage when the postings at South 1; South 2; South 3; South 4; South 5; Pavilion Mezzanine; North 1; and North 2. did not include the required information residents may a file complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. Failure to post contact information for State agency did not ensure residents and family members were aware which State agency to contact to report abuse/neglect. Findings: 1 a) Review of Resident 2's Face Sheet indicated Resident 2 was admitted to the facility on 11/25/15 with a diagnosis of pneumonia (lung infection). Review of the "Social History Assessment" dated 12/03/15 notes that Resident 2 is her own decision maker. No "x" was marked under items reviewed for Advanced Directive. The assessment was completed and signed electronically by Licensed Clinical Social Worker (LCSW). 1 b) Review of Resident 5's Face Sheet indicated Resident 5 was re-admitted to the facility on 2/04/16 with pneumonia (lung infection). Review of the "Social History Assessment" dated 2/09/16 notes that Resident 5's brother is the Surrogate Decision Maker. No "x" was marked under items	F 156	The Director of Social Services will be notified weekly by the Social Services Support staff the names of residents who are newly admitted to the facility. Social Workers are responsible for submitting completed Resident Social History Assessments of newly admitted residents to the Director of Social Services, who will review the completed Assessments for required documentation on Advance Directives. If information is missing or unclear, the Director of Social Service will inform the involved of Social Worker of findings of the review and request that additional documentation be made to address the missing or unclear information. Assistant Hospital Administrator is responsible for monitoring compliance. A random sampling of 10 charts will be reviewed monthly by the Director of Social Services to monitor facility compliance with Advance Directives. Results of the audit will be reported at the skilled nursing facility (SNF) Performance Improvement and Patient Safety (PIPS) Committee on a bi-annual basis. Assistant Hospital Administrator is responsible for reporting compliance. 2. The facility provides information to residents on how and where to file a complaint concerning resident abuse, neglect; and misappropriation of resident property in the facility; and non-compliance with the advance directives requirements through bulletin board postings.	10/13/16 and on-going 10/13/16 and on-going

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F 156	Continued From page 4 reviewed for Advanced Directive. The assessment was completed and signed electronically by Master of Social Work (MSW). 1 c). Resident 11 was admitted in the facility on 10/1/14 with diagnoses including Alzheimer's dementia (difficulty in remembering recent events); depression (persistent feeling of sadness); Gastroesophageal reflux disease (GERD- stomach acid and content flows back into the esophagus). Review of Resident 11's "Social History Assessment" dated 10/10/14 indicated, Resident 11's daughter was the surrogate decision-maker (SDM). There was no mark on the assessment form advance directive was reviewed with the resident or SDM. The assessment was completed and signed signed by Social Worker. 1 d). Resident 15 was admitted to the facility on 9/2/14 with diagnoses including Alzheimer dementia (problems with thinking and memory), tardive dyskinesia (repetitive body movements), and hyperlipidemia (elevated blood cholesterol). Review of Resident 15's Minimum Data Set (MDS, a resident assessment tool to facilitate care) dated 9/8/15 indicated, Resident 15's decision making skills was moderately impaired. His sister served as his SDM as documented in his social work assessment dated 9/8/14. Review of Resident 15's "Social History Assessment" dated 9/8/14 did not have a mark that advance directive was reviewed with the resident's SDM. 1 e) Resident 19 was admitted to the facility on 11/4/15 with diagnoses including hypertension	F 156	The Consumer Information document, posted on neighborhood bulletin boards, was revised with a larger font for increased visibility by the residents. The updated document was posted on the 13 neighborhood bulletin boards. The facility also standardized the location of Consumer Information postings and other documents containing information for residents on the 13 neighborhoods. Educational slides on the updated content of the Consumer Information posting and its location was provided to neighborhood staff. The slides also contain instructions to staff on identifying and reporting missing or incorrect informational posting to their managers. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material provided. The facility's Administration staff or designee is responsible for maintaining and updating the Consumer Information postings on a timely basis, and or whenever a change is required. The neighborhood Nurse Manager, or designee is responsible for monitoring that the bulletin board on their respective neighborhood has the most updated document produced. The neighborhood Nurse Manager is responsible for reporting any missing or incorrect posting information to Administrative staff.	10/4/16 10/13/16 10/13/16 10/13/16 and on-going 10/13/16 and on-going

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(increase in blood pressure), congestive heart failure (CHF- inability of the heart to pump sufficient blood), and end stage renal failure (ESRD - loss of kidney function).

Review of Resident 19's MDS dated 11/17/15 indicated, Resident 19 was cognitively intact.

Review of Resident 19's "Social History Assessment" dated 11/10/15 did not have a mark that advance directive was reviewed with the resident.

During interview on 9/9/16 at 10:07 AM, Social Worker (SW 1) stated, "The discussion regarding advance directive is done by the resident doctors during admission".

Review of facility policy and procedure on "Advance Care Planning", dated 3/25/08, indicated, "...3. Residents are provided information about their rights to make medical decisions at the time of admission...4. If a resident lacks capacity, decisions made by surrogate decision-makers (SDM) are honored...iii...Documents in the social work assessment, if information regarding advance health care directives was provided to resident and SDM."

1 f) Review of Resident 22's Face Sheet indicated Resident 22 was admitted on 10/20/11 with the diagnosis of urosepsis (blood poisoning). Review of the "Social History Assessment" dated 10/26/11 indicated no "x" was marked under items review for Advanced Directive. The assessment was completed and signed by MSW.

Record review indicated Resident 22 completed a

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California Advance Health Care Directive on 9/14/2011 delegating two family members as his health care agents. Under the designated agents was a box marked indicating "My health care agent can make decisions for me now". In a medical note on 8/15/16, the doctor indicates the resident "is his own decision maker".

Resident 22's MDS record dated 07/21/16 section S indicates the CA POLST (California Physician Orders for Life Sustaining Treatment) was not completed.

Resident 22's medical progress note under Advanced Directive, dated 8/15/16, indicates "the patient is his own decision maker". This note was signed electronically by the physician.
1 g) Review of the Face Sheet indicated Resident 26 was admitted to the facility on 8/31/16. The History and Physical Examination document dated 8/31/16 indicated a diagnosis that included End Stage Renal Dialysis (ESRD - the last stage of chronic kidney disease) on Hemodialysis (a machine that filters wastes, salts and fluid from the blood when the kidneys no longer able to do its this work adequately).

Review of the Physician's Notes dated 8/31/16 indicated an Advance Directives (ADs are legal documents that allow a person to spell out his/her decisions about end-of-life care ahead of time) Note as Full Code (means all appropriate measures, including cardio-pulmonary resuscitation shall be attempted) Status and resident was her own decision maker, electronically signed and dated by the physician on 8/31/16 at 7:31 PM.

Review of the Resident Social History

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Assessment Form 9/6/16 indicated, the Items Reviewed section had a box marked for Abuse Reporting Process but the box for Advance Directive was unmarked, electronically signed and dated by the Licensed Clinical Social Worker on 9/6/16.

1 h) Closed chart review indicated Resident 30 was re-admitted to the the facility on 5/16/16 and discharged from the facility on 6/9/16.

Review of the Physician's Notes dated 5/16/16 indicated an advance directive: full code status, electronically signed and dated by the physician on 5/16/16 at 12:58 PM.

Review of the "Resident Social History Assessment Form", dated 9/27/12, indicated the box for advance directive was unmarked.

In a group interview with the Facility Management Staff on 9/13/16 at 10:08 am, the Social Service Director (SSD) stated that for the Advance Directives (AD) there were two tracks, Legal and Clinical. For Legal track, the facility would obtain a copy of the AD if available and if resident did not have one, then, assistance to make AD would be provided. For the Clinical track, the physician would talk to the resident in detail. If resident is cognitively impaired, the Surrogate Decision Maker (SDM- also known as a health care proxy are advocates for patients unable to make informed decisions)/family member would come to a team meeting, and, if there was no SDM then Conservatorship and Probate would be initiated. When asked how education was provided, the SSD stated it was the role of the Social Worker (SW) to provide information to residents about Advance Directive. SSD stated SW should be

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marking the box when they discussed it with the resident. And, if the box for the AD was checked (or marked) then the staff had offered and if it was not checked, if resident was unable to due to cognitive impairment, then, there should had been a discussion why they (staff) were not marking it.

1-I. Resident 8 was originally admitted on 10/1/87 and was re-admitted on 4/9/15 with diagnoses including acute cholangitis (infection of the bile duct), seizure disorder and hypertension. Review of the annual comprehensive assessment dated 6/15/15 and 6/16/16 indicated Resident 8's cognitive skills for daily decision making was severely impaired.

Review of a document titled, "Advance Directive Note" electronically signed by MD 1 on 4/9/15 indicated, " DNR/DNI (Do not Resuscitate/Do not Intubate) transfer out of facility ok."

Review of the Resident Social History Assessment dated 10/8/14 indicated there was no evidence of information provided, interview or discussion regarding formulation of an Advance Directive.

During an interview with the Director of Social Services on 9/13/16 at 10 AM, she said the social worker is responsible for providing written information or resident handbook on admission to the resident or surrogate decision-maker regarding advance directive. She acknowledged that there was no documentation indicating that information was provided to the resident's surrogate decision-maker.

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2) On 9/9/16 at 9:57 AM, accompanied by Nursing Director (ND 2) at the Pavilion Mezzanine (PM), an observation of consumer information posting was done. There was no information posted informing consumers that they may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives. ND 2 acknowledged the findings and stated, "That's one thing that we can look on and will add on the board."

During observation on 9/13/16 at 11:01 AM, accompanied by Nurse Manager (NM 1), the South 2 consumer board did not have a required information that consumers may file a report with the State survey and certification agency regarding allegations of abuse/neglect. NM1 acknowledged the findings and stated, "The statement is not there, only for ombudsman."

During observation on 9/13/16 at 11:05 AM, accompanied by Nurse Manager (NM 2), the South 3 consumer board did not have required information consumers may file a report with the State survey and certification agency regarding allegations of abuse/neglect. NM 2 acknowledged the findings and stated, "The statement is not here."

During observation on 9/13/16 at 11:11 AM, accompanied by Nurse Manager (NM 10), the South 3 consumer board did not have a required information that consumers may a file complaint with the State survey and certification agency. NM 10 acknowledged the findings.

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F 156	Continued From page 10 During observation on 9/13/16 at 11:18 AM, accompanied by Nurse Manager (NM 9), the South 3 consumer board did not have a required information that consumers may a file complaint with the State survey and certification agency. NM 9 acknowledged the findings and stated, "The statement was not specifically mentioned here."	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to promote care that enhances dignity for one of 43 sampled residents when a sign was posted on the wall in Resident 31's room that stated, "Vision and Hearing Impaired". The deficient practice could potentially negatively impact resident's self-esteem. Findings: Resident 31 was admitted on 12/31/15 with diagnoses including Type 2 diabetes, sepsis secondary to perforated diverticulitis (infection due to pouches in the intestine). Review of the Minimum Data Set, an assessment tool dated 7/25/16 indicated Resident 31 had moderate cognitive impairment. The Resident was able to perform activities of daily living	F 241	The facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The Nurse Manager promptly placed a cover sheet on the care alert information for Resident 31. Resident 31 was interviewed by the Nurse Manager with assistance of the Bay Area Communication Access (BACA) interpreter service, and expressed that she receives respectful care at the facility. Charge Nurses on the 13 neighborhoods were instructed to check each resident's room to verify that there was a cover sheet on care alerts that are posted on walls in resident rooms in support of resident dignity and respect. A standardized cover sheet titled "Care Alert" will be created and distributed for use on the 13 neighborhoods. Individualized resident care information will be placed on the inside of the "Care Alert" cover sheet as deemed necessary for continuity of quality care. The Charge Nurse or designee is responsible for monitoring that resident health information is protected from view by the cover sheet.	9/8/16 9/13/16 9/8/16 10/13/16

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F 241	Continued From page 11 (transfer, walking, dressing, eating toilet use and personal hygiene) independently. She has moderate hearing difficulty and used a hearing aid. She has impaired vision, able to see large print, but not regular print in newspaper/books. She used corrective lenses. During environmental tour on 9/8/16 at 3:25 PM, a visible sign was posted on the wall in the Resident 31's room that stated, "Vision and Hearing Impaired". During an interview on 9/8/16 at 3:30 PM, Registered Nurse (RN) 3, acknowledged that the resident's disability should not be exposed. He said, "It's a privacy violation." He took down the posted sign.	F 241	A read and sign review of educational slides will be provided to nursing staff reminding them of the facility's standard on promoting resident dignity and respect and use of the new "Care Alert" cover sheet. The Nurse Educator is responsible for developing the educational slides. Nurse Managers are responsible for monitoring staff compliance with review of the instructional material. Nurse Managers are assigned to conduct monthly check-ins with residents and monitor if the resident's confidential health information is protected from view through use of the "Care Alert" cover sheet. Results of the monthly resident check-ins will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC), and bi-annually to the Performance Improvement and Patient (PIPS) Committee. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. The Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 10/13/16 and on-going
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	The facility has implemented policies and procedures for utilizing the results of resident assessments to develop, review and revise the resident's comprehensive care plans and promote the resident's highest level of physical, mental, and psychosocial well-being. 1. A special review meeting was held on 9/12/16 by the Resident Care Team (RCT) to discuss Resident 11's required amount of fluid intake. The physician gave new orders and reduced the amount of required daily fluid intake. The resident care plan related to nutritional intake, including risk for dehydration and constipation, was revised by the Registered Dietitian to reflect the physician's latest orders.	10/7/16

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F 279	Continued From page 12 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a comprehensive plan of care for three of 43 sample residents (Resident 11, 17, and 7) when: 1. There was no care plan to address a physician order regarding fluid intake for Resident 11. 2. The use of self-release belt was not addressed in Resident 17's fall precaution care plan. 3. There was no care plan to address nutritional problem for Resident 7. Failure to establish, review, and revise Residents 7, 11, and 17's plan of cares may negatively impact the physical, mental, and psychosocial well-being of these residents. Findings: 1. Resident 11 was admitted to the facility on 10/1/14 with diagnoses including Alzheimer's dementia (difficulty in remembering recent events); depression (persistent feeling of sadness); gastroesophageal reflux disease (GERD- stomach acid and content flows back into the esophagus). Review of physician's annual assessment dated 10/26/15 indicated Resident 11 has constipation and excessive sweating. Resident 11 was noted by daughter as "more thirsty and sweaty when	F 279	2. Resident 17's care plan on risk for fall was revised by the licensed nurse to include the use of a self-release belt. 3. Resident 7's care plan related to nutritional needs was revised by the Registered Dietitian to include more specific interventions (e.g. provision of 1920 to 2200 kcal puree consistency diet with 65 to 85 g of protein). The revised care plan is comprehensive and addresses Resident 7's nutritional risk factors, establishes measureable goals/objectives and timetables to meet the resident's nutritional needs that are identified through the comprehensive assessments of the RCT. The care plans of other residents who have physician orders for specific fluid requirements, use a self-release belt to minimize risk of falls, and have nutritional problems that are not meeting established objectives/goals have been reviewed and revised as necessary by the appropriate member of the RCT. Nurse Managers are responsible for monitoring compliance with facility standards. A read and sign review of educational slides will be provided to the RCT reminding them of facility standards on developing comprehensive care plans with measurable objectives and timetables, that are based on the results of resident assessments, to attain or maintain the resident's highest level of physical, mental, and psychosocial well-being. The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional material.	9/12/16 10/4/16 10/13/16 10/13/16

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F 279	Continued From page 13 she had unfamiliar care providers." Review of Resident 11's physician's order for September 2016 indicated, "...Push P.O. (per orem = taken by mouth) fluids and ensure that resident takes in at least 2800 cc (cubic centimeter a unit of volume) (which is equal to 2.8 liters) of fluids daily..." The fluid intake was ordered for prevention of "dehydration and constipation." During an interview on 9/9/16 at 2:28 PM and concurrent record review, the Nurse Manager (NM 8) acknowledged there was no plan of care that addressed hydration and fluid intake for Resident 11. She stated, "We did not see it to be care plan specifically as 2.8 liters of fluid intake. Fluid intake is part of nutrition care plan." However, further review of Resident 11's care plan for nutrition and prevention of constipation did not include physician's order for fluid intake of "at least 2800 cc daily." 2. Resident 17 was admitted to the facility on 7/21/05 with diagnoses including hypertension (increase in blood pressure), advance vascular dementia (decline in memory due to reduction of blood flow in the brain), paranoid ideation (false thoughts of being harassed or persecuted). On 9/9/16 at 11:40 AM, Resident 17 was observed sitting in a wheelchair eating lunch at the great room with a seat belt strapped across her waist. Review of Resident 17's physician's order for September 2016 indicated "Self-release seat belt with alarm in wheelchair for safety" with an order date of 6/30/16.	F 279	Neighborhood Charge Nurses are assigned to review and revise resident care plans when Monthly Nursing Summaries are due to ensure that the care plans are comprehensive and addresses resident needs. Clinical Nurse Specialists or designee will be assigned to conduct 5 Care Plan QAs monthly per neighborhood to verify that care plans are comprehensive and consistent with current interventions. Results of the QA will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC) and bi-annually to the Performance Improvement and Patient Safety (PIPS) Committee. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 and on-going

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Review of Resident 17's care plan for fall prevention found no documented evidence for the use of a self-release seat belt. During an interview on 9/9/16 at 12:03 PM, the Nurse Manager (NM 11) stated, "It's not in the care plan. It should be in the care plan to make sure that the staff are aware and to monitor if the intervention is effective. If not then we can find other intervention to prevent her from falling."

Review of facility policy and procedure titled "Resident Care Plan, Resident Care Team & Resident Care Conference", dated 5/25/2010, indicated, "Policies: 1...Resident Care Team,...shall develop a comprehensive plan of care, based on the care team disciplines' assessment, that includes measurable objectives and a time table to meet the resident's medical, nursing, and mental health needs... 6...Unstable, alterable problems that require a more goal directed approach are addressed on the Resident Care Plan..."

3. Resident 7 was admitted on 11/28/12 and re-admitted on 8/9/16 with diagnoses of pain, pressure ulcer and excessive weight loss.

Review of the admission Minimum Data Set, an assessment tool, dated 8/26/16 indicated Resident 7 was cognitively impaired, he needed extensive assistance with bed mobility, and full staff assistance with transfer, eating, toilet use and personal hygiene. He had weight loss of 5% or more in the last month and was on a mechanically altered diet.

Review of the weight record indicated the following:

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Date . Weight

7/21/16 165 lbs. (pounds)
8/9/16 196 lbs.
8/18/16 177 lbs.
8/31/16 159 lbs.
9/4/16 162 lbs.
9/7/16 163 lbs.

Review of the Integrated Progress Notes by the Registered Dietitian (RD) 2 dated 9/8/16 at 1 PM indicated, "Resident had significant weight loss during acute admission last month. Weight loss probably d/t (due to) fluid loss r/t (related to) edema and also change in functional status. Diet was downgraded to puree sec (secondary) to possible change in medical condition causing decreased strength and overall behavioral issues causing changes in eating pattern..."

Review of the resident care plan indicated Resident 7 was at nutritional risk related to diabetes mellitus Type 2, vascular dementia, behavioral problem, swallowing problem, and pressure ulcer. The care plan also identified the need for mechanically altered texture d/t (due to) swallowing difficulty; Resident had significant weight gain of 25# (14.6%) X 1 month; Resident had +3 in lower extremities and both hands; Significant weight loss of 19# (9.7) X 9 days; Resident at risk for weight loss d/t recent episode of weight loss, vascular dementia, and behavioral problem.

The care plan interventions included the following: 8/23/16 Diet: Pureed, 1:1 feeding assistance with standard aspiration precautions; Glucerna (reduced sugar nutritional shake) 1 can TID (three times a day) if intake < 50%; Resident

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F 279	Continued From page 16 receives Vit. D3." During an interview on 9/9/16 at 11:40 AM, RD 2 acknowledged she did not update the care plan to address the significant weight fluctuation of the resident. She said the weight loss was related to the diet change to pureed diet and behavioral problems. Resident had edema of the extremities that caused the significant weight gain. During an interview with Nurse Manager 10, she agreed that the interventions did not include specific steps to address the all risk factors identified. The interventions did not include how the the facility plans to monitor the progress of the resident.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet professional standard of quality care when : 1. Nursing staff failed to implement physician's order to provide sufficient fluid intake of 2,800 ml (milliliter a unit of volume, equals to 2.8 liters) for one of 43 sample residents (Resident 11). This deficient practice may place Resident 11 at increased risk for dehydration. 2. RN 5 did not follow physician order for	F 281	The facility hires qualified licensed professionals and provides care and services that meet professional standards of quality. 1. A special review meeting was held on 9/12/16 by the Resident Care Team (RCT) to discuss Resident 11's required amount of fluid intake. The physician gave new orders and reduced the amount of required daily fluid intake. The resident care plan related to nutritional intake, including risk for dehydration and constipation, was revised by the Registered Dietitian to reflect the physician's latest orders. 2. The physician revised the respiratory treatment orders for Resident 32 and ordered BiPAP 15/5 cm bleed in oxygen at 2 liters per minute at hour of sleep (HS) on 9/7/16. Resident 32 appears more comfortable with the new orders requiring BiPAP treatment only at night.	10/7/16 10/4/16

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F 281	Continued From page 17 Resident 32 when oxygen was administered at 2.5 liters (L) /minute (min.). Findings: 1. Resident 11 was admitted to the facility on 10/1/14 with diagnoses including Alzheimer's dementia (difficulty in remembering recent events); depression (persistent feeling of sadness); gastroesophageal reflux disease (GERD- stomach acid and content flows back into the esophagus). Review of physician's annual assessment dated 10/26/15 indicated Resident 11 has constipation and known to have excessive sweating. Resident 11 was noted by daughter as "more thirsty and sweaty when she had unfamiliar care providers." During observation on 9/7/16 at 8:50 AM, Resident 11 was in the great room eating breakfast. There was no staff assisting the resident during feeding. During interview on 9/7/16 at 9:41 AM, Certified Nurse Assistant (CNA 4) stated, Resident 11 need assistance with setting up of foods and drinks but not with feeding. Review of Resident 11's functional status at Minimum Data Set (MDS an assessment tool) dated 10/1/15 and 6/29/16 indicated, resident requires extensive assistance on feeding. Review of Resident 11's physician's order for September 2016 indicated, "...Push P.O. (per orem = taken by mouth) fluids and ensure that resident takes in at least 2800 (ml) of fluids daily..." The fluid intake was ordered since	F 281	Nurse Managers reviewed and verified with licensed nurses that other residents with physician orders for fluid requirement or restriction, oxygen and respiratory treatment for CPAP or BiPAP; were being carried out as written. The Clinical Support Services Manager reviewed and verified that residents who have orders for CPAP or BiPAP treatment have the correct machine settings according to Physician orders. A read and sign review of educational slides will be provided to 24/7 licensed Nursing staff reminding them of facility standards on carrying out treatment orders as prescribed by the physician and according to professional standards of quality. The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional material. The LVN QA Nurse will be assigned to conduct monthly intake and output reviews to verify that residents on fluid restriction or with required fluid intake are receiving the amount of fluids ordered by the physician. Results from the QA will be reported to respective Nurse Managers for follow-up. Monthly data will be aggregated and reported quarterly at NQIC and bi-annually at PIPS Committee meetings. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	9/30/16 10/4/16 10/13/16 and on-going

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F 281	Continued From page 18 5/20/15 for prevention of "dehydration and constipation" and remains an active physician's order. During record review and concurrent interview on 9/7/16 at 11:58 AM, Resident 11's treatment record dated 1/1/16 to 9/6/16 indicated, the total daily fluid intake of Resident 11 ranges from 1180 ml to 2400 ml of fluid daily. The goal fluid intake of "at least 2800 ml/ daily" was not provided to the resident. Registered Nurse (RN 2) acknowledged the findings. During interview on 9/9/16 at 2:28 PM, Nurse Manager (NM 8) acknowledged that Resident 11 was not able to take the total fluid intake according to physician's order. NM 8 was not able to present any documented evidence the physician was made aware of Resident 11 was unable to drink 2,800 ml per day. NM 8 also acknowledged that there was no care plan to address Resident 11's hydration status. 2. During initial tour accompanied by RN 5 Nurse Manager (NM) 10 on 9/6/16 at 10:50 AM, Resident 32 was awake in bed with a C-PAP machine set at 15/5 with oxygen at 2.5 L/min. RN 5 and NM 10 both confirmed that the oxygen was on at 2.5 L/min. CPAP machine (continuous positive airway pressure)- is a non-invasive form of therapy for patients suffering from sleep apnea. BiPAP (also referred to as BPAP) stands for Bilevel Positive Airway Pressure, and is very similar in function and design to a CPAP. Both CPAP and BiPAP machines allow patients to	F 281	The Respiratory Therapist or designee will conduct Monthly QAs on residents on CPAP and BiPAP verifying that machine settings and treatment are provided according to Physician orders. Data from the QA will be aggregated quarterly and submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Clinical Support Services Manager. Chief Medical Officer and Chief Nursing Officer are responsible for reporting compliance. The Clinical Nurse Specialist will conduct weekly QAs on delivery of professional services to verify that services meet quality standards that includes clinical interventions, assessments and evaluations. Results of weekly professional services QA will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC) and bi-annually to the PIPS Committee. Nursing Program Directors are responsible for quarterly reporting compliance to NQIC. Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 and on-going 10/13/16 and on-going

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breathe easily and regularly throughout the night.

During an interview on 9/6/16 at 11 AM, Respiratory Therapist said sometimes the oxygen gauge would fluctuate and staff should adjust it to keep it at 2 L/min.

During interview on 9/6/16 at 11:05 AM, RN 5 stated she took the C-Pap off during breakfast, placed it at the bedside then reapplied it after resident finished eating his breakfast. She said resident refused to remove the Cpap machine but the physician was not notified. At 11:20 AM, RN went to check Resident 32's oxygen saturation level. She said it was 96%.

Review of the physician's order for Resident 32 dated 2/12/16 indicated, "C-PAP setting 15/5 to rise q (every) HS (hour of sleep) for OSA (Obstructive Sleep Apnea). O2 via nc (nasal cannula) prn (as necessary) O2 < or = (less or equal) 92%.

Review of the following Integrated Progress Notes show respiratory treatment given during non-sleeping hours:

"On 8/3/16 at 11:15 AM, Resp. (respiratory): O2 in use at 2L/min. bleed in to BiPAP.
On 8/9/16 at 11:10 AM, Resp.: O2 in use at 2L/min. bleed into BiPAP.
O 8/10/16 at 1525 (3:25 PM) , Resp.: O2 in use at 2L/min. via bleed in to BiPAP.
On 9/1/16 at 10 AM, Resp.: O2 at 2L/min. bleed in.
On 9/1/16 at 1300 (1 PM) Resident awake and verbally responsive.... 97% on CPAP."

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F 309 SS=D	Continued From page 20 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide necessary care and services according to the plan of care for three out of 43 sampled residents (Residents 26, 33, and 34) when: 1. For Resident 26, the care plan for hemodialysis was not implemented. This deficient practice may increase the risk for errors regarding dialysis. 2. For Resident 34, the care plan for seizure precaution was not implemented. This deficient practice may increase Resident 34's risk for injuries during a seizure. 3. Perishable food items in Resident 33's room were not removed according to his care plan. This may lead to an unsanitary environment. Findings: 1. Review of the Resident 26's Face Sheet indicated she was admitted to the facility on 8/31/16. The History and Physical Examination document dated 8/31/16 indicated multiple	F 309	Laguna Honda has developed and implemented written policies and procedures for providing residents with necessary care and services to attain or maintain his/her highest practicable physical, mental, and psycho-social well-being, in accordance with the comprehensive assessment and plan of care. 1. Nursing staff placed Care Alert signage at Resident 26's head of bed indicating "No IV or Blood Draw, No BP on Left Arm." 2. The side rails of Resident 34's bed were padded and the care plan was updated by the licensed nurse to reflect current interventions for seizure precautions. 3. Expired perishable food items were removed from Resident 33's room after the Nurse Manager discussed the importance of keeping a sanitary environment with the resident. Nursing staff provided Resident 33 with sealed containers to store perishable food that resident wished to keep at bedside.The container was labelled with a discard date for the perishable food item. Nurse Managers instructed Nursing staff to verify that necessary Care Alert signage for residents on hemodialysis were appropriately placed at head of bed, that side rail pads were provided for residents at risk of seizure, and that expired food items are removed from the resident's bedside table and storage areas.	F 309 9/8/16 9/6/16 10/13/16 9/30/16

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F 309	Continued From page 21 diagnoses including end stage renal dialysis (ESRD - the last stage of chronic kidney disease) on hemodialysis (a machine that filters wastes, salts and fluid from the blood when the kidneys no longer able to do its this work adequately). In an interview on 9/8/16 at 10:25 AM, the Nurse Manger (NM) 1 stated Resident 26 had dialysis three times a week on her left arm A-V (Atrio-venuos) shunt (surgically created vein used to remove and return blood during hemodialysis). In an observation on 9/8/16 at 10:25 AM, with the Nurse Manager (NM) 1 and Registered Nurse (RN) 1 Resident 26 was observed in bed asleep and the Certified Nurse Assistant (CNA) 1 was at the bedside. There was no sign at the head of the bed that would alert the staff not to use Resident 26's left arm with the shunt to obtain a blood pressure reading or blood draw. Review of the Resident Care Plan dated 8/31/16 it indicated the problem : "Chronic Renal Failure on hemodialysis and one of the interventions listed was "Do Not use access device to take BP (Blood Pressure), start IV (intravenous) or draw blood. In an interview on 9/8/16 at 10:28 am. both the NM 1 and RN 1 acknowledged the missing sign at the head of the bed. RN 1 and CNA 1 stated they would "get one" (sign to post at the head of the bed). When asked, NM 1 stated it would be a "good alert" for the staff. Review of the facility policy and procedure titled, Management of Residents on Hemodialysis, File: K 9.0, dated: 7/4/15, " ... Procedure: ... C. Venous Access Precautions: ... 3. Venipuncture for	F 309	A read and sign review of educational slides will be provided to 24/7 Nursing staff reminding staff of the facility's standards for managing the care of residents on hemodialysis; use of side rail pads for residents at risk of seizure activity to reduce the resident's risk of injury; and the importance of keeping a sanitary room environment for the resident who has difficulty parting with food items provided or purchased. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Charge Nurses are responsible for conducting daily environmental rounds to maintain a sanitary room environment for the resident; verifying that expired perishable food is discarded, that food kept at the resident's bedside is stored in sealed plastic containers, is properly dated and labelled. Results of environmental rounds will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC), and bi-annually to the Performance Improvement and Patient (PIPS) Committee. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. The Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 10/13/16 and on-going

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F 309	Continued From page 22 laboratory tests, I.V. (intravenous) fluids, or taking blood pressure may not be performed on the extremity with dialysis access. A sign should be posted at the head of the bed to alert health team members not to use extremity with shunt or fistula. ... ." Further review of the Resident Care Plan, dated 8/31/6, indicated interventions that included: "1. assessment for bruit (rushing-roaring sound, with a stethoscope placed over the fistula/graft) and thrill (palpable murmur) of the AV shunt every shift 2. vital signs daily and upon return from dialysis 3. do not use access devices to take BP (blood pressure) , start IV (Intravenous), or draw blood, 4. Use Dialysis Communication Form to communicate any information relevant tot he resident ... ." Review of the Medication/ Treatment Record (M/TR) for the month of September, 2016 indicated missing information as follows: a.) License Nurse's initials on the "Day Shift" were documented except on 9/2/16, 9/5/16, and 9/10/16 that would indicate an assessment were done to check the presence of an audible bruit and palpable thrill every shift. The "AM" and "PM" shifts for each day had the initials of the LN(s). b.) The Vital Signs (VS - are clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure that indicate the state of a patient's essential body functions) upon return from dialysis treatment was missing on 9/5/16. The M/TR form indicated check V/S upon return from dialysis treatment. c.) There was no evidence the resident's weight was taken prior to dialysis for each day Resident 26 had dialysis treatment.	F 309	Clinical Nurse Specialists will be assigned to conduct a monthly QA of residents on Hemodialysis and Seizure precautions to ensure staff are carrying out the standards of care per LHH Nursing policies and procedures. Results of the QA will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC), and bi-annually to the Performance Improvement and Patient (PIPS) Committee. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. The Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 and on-going

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a.) In an interview on 9/13/16 at 8:35 am, the NM 1 stated the staff should assessed the presence of bruit /thrill every shift and after searching thru the clinical records and the Electronic Health Record (EHR), NM 1 stated there were no documentation of the assessment anywhere in the chart and the EHR.

Review of the facility policy and procedure titled, Management of Residents on Hemodialysis, File: K 9.0, dated: 7/4/15. Policy: ... 6. The Licensed Nurse will monitor the A-V shunt and fistula for audible bruit and palpable thrill at least daily ... . Procedure: ... B. ... 5. Assess shunt for thrill and bruit. ... F. Documentation ... 2. Treat Assessment Record (TAR), a. Document presence or absence of AV shunt /fistula audible bruit and palpate thrill ... .

b.) In an interview on 9/8/16 at 10:42 am. the Registered Nurse (RN) 1 looked at the M/TR form and acknowledged that on 9/5/16 there were missing vital signs information and signature(s) of the LN(s) on the MT/R form. RN 1 could not explained why there was no documentation, "she should put something there." When asked, RN 1 stated it was to make sure the resident was "stable" after the dialysis, because sometimes residents could have a "low blood pressure" upon return following dialysis treatment.

Review of the facility policy and procedure, Management of Resident on Hemodialysis, date revised: 7/14/15. ... Procedure: ... B. Care Immediately After the Dialysis: ... 6. Perform vital signs upon return from dialysis . ... .

c.) Further review of the M/TR form dated September, 2016 indicated,"Check ... weight prior

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to dialysis treatment". There was no evidence it was done. Review of the Dialysis Communication Form dated 9/4/16 and 9/9/16 the area that indicated "From ... (name of the facility) to Dialysis Center" did not have any documentation that weight was taken prior to dialysis.

In an interview on 9/13/16 at 8: 55 am, NM 1 searched both the clinical records and the Electronic Health Record and acknowledged there was no documentation weight was taken each day Resident 26 went for dialysis. NM 1 stated weight was done only a weekly basis according to the Admission Order (on 8/31/16).

Review of the facility policy and procedure Management of Resident on Hemodialysis, date revised: 7/14/15. Policy: Nursing interventions for pre and post hemodialysis are planned ... Procedure: A. Care Before Dialysis:, 1. .. c. Vital signs and weight are taken ... prior to sending residents to dialysis. Weigh residents at the same time each day, on the same scale with the same clotting. ... .F. ... 6. Dialysis Communication Form: Communication ... between dialysis nurse and unit nurse resident's information ... such as : lab (laboratory results), weights, vital signs ... .

2. Random Resident 34 was admitted on 8/27/13, with diagnoses that include right thalamic stroke (blood supply is cut off in the right side of the thalamus [plays a role in controlling the motor systems of the brain which are responsible for voluntary bodily movement] which affects the opposite side of the body), hypertension (high blood pressure), dementia, and seizure (often used interchangeably with convulsion; occur when a person's body shakes rapidly and

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uncontrollably).

During observation on 9/6/16, at 10:00 AM, with Nurse Manager (NM) 4, Random Resident 34 was laying in bed with 4 side rails up. NM 4 stated Random Resident 34 was on "seizure precaution". All four side rails were not padded. During a concurrent interview, NM 4 was asked if the side rails should be padded. NM 4 stated he will check.

Review of the care plan for risks for seizure and seizure inducing injury, revised on 6/16, indicated..."Goal: Will be free from injury and safe during and post seizure. Intervention:...Padding side rail of bed and W/C (wheelchair)...".

Review of facility document titled "Seizures Appendix 1," revised October 2001, indicated..."Seizures...Interventions:..3. Pad furniture to protect resident from injury during seizures."

3) Review of Resident 33's face sheet and his Minimum Data Set (MDS, a standardized resident assessment to facilitate care management), dated 11/05/15, indicated he was admitted to the facility on 4/11/08 with multiple diagnoses including heart problem, high blood pressure, and blood sugar problem. According to his MDS assessment, Resident 33 had no problems with memory, judgment, and reasoning. Resident showed no signs of mood or behavioral concerns and was not resistant to care. Resident 33 had upper extremity impairment on one side and lower extremity impairment on both sides. Resident 33 required extensive assistance of one staff with bed mobility and was totally dependent on one staff for transfers. Resident 33 required

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extensive assistance of one staff for locomotion off the unit.

During an observation on 9/6/16 at 12:30 PM, Resident 33's room had multiple items of spoiled perishable food with flies. These items included but were not limited to: a plastic container with sandwich covered in white, black and green substance, two open containers of lemon wedges with flies, and open container of sliced peaches with flies and a brown mug with liquid residue and flies.

During an interview on 9/6/16 at 12:40 PM, Charge Nurse (CN) 1 stated "...(Resident 33) gets very angry if we take his food away so we ask him first if it is ok. I will ask him later today." CN 1 stated" It appears to be an old sandwich covered in mold and (has) been there for a very long time".

During an interview on 9/6/16 at 12:50 PM, Nursing Director (ND 1) stated "The food should have been removed from the room. This is a problem and we have a care plan for this resident due to hoarding issue".

During observation on 9/9/16 at 9:35 AM, flies were observed in Resident 33's room.

During an observation on 9/13/16 at 10:00 AM, in Resident 33's room, there were four containers of undated baked goods: a pumpkin pie with four white fuzzy spots on top and side, a white cake, a yellow cake, and a chocolate cake. There was an open milk carton with a straw, a blue cup with chunks of fruit at the bottom. Additionally, three flies were seen flying around in Resident 33's room.

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F 309	Continued From page 27 During a concurrent interview, Nurse Manager (NM 5) stated, "I think that is mold on the pumpkin cake. (Resident 33) gets very upset if we remove anything from his room, so we don't remove anything unless it is ok with him". Review of Resident 33 ' s care plan, dated 10/8/13, indicated a problem for: risk of food poisoning, safety/infection control issue related to hoarding food that is left open at bedside and quickly expires. A goal was set that Resident 33 would " allow staff to remove old and expired food from bedside on a daily basis " . To attain this goal, the care plan indicated that the Certified Nurse (CN) and the CNA " will check his bedside each evening at 10 PM and remove all open food ...dispose of expired food ...check in with resident weekly about keeping his bedside clean, and have ...(a pest control company) check in on room 2 times weekly " .	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the environment remained as free of accident	F 323	The facility maintains an environment as free of accident hazards as possible; and provides each resident with adequate supervision and assistive devices to prevent accidents. 1. The domestic hot water supply temperature has been adjusted to 115 degrees. The hot water temperature has been adjusted to alarm at 120 degrees. An automatic page via the Building Management System of the hot water alarm activation will be sent to the 24 hour Watch Engineer and Engineering Supervisors.	9/8/16

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F 323	Continued From page 28 hazards as possible when: 1. Water temperature in three resident rooms in the North One (rooms 28, 31, and 43) were above 120 degrees Fahrenheit (F). Failure to ensure water temperature for residents were below 120 F may place these residents at increased risk for burn injuries. 2. The hand sanitizer in North 4, room 12 did not have a drip tray. Failure to prevent fluid from dripping onto the floor may place residents at increased risk for fall injury. 3. One resident's bed in Room South 541 A was unlocked that could potentially cause a resident to fall when transferring to and from the bed. Findings: 1. During environmental tour accompanied by the Nurse Manager (NM) 5 , Environmental Services (EVS) Director and the Building and Grounds Supervisor on 9/8/16 at 3:07 PM, the water temperatures according to the facility's thermometer showed the following: In the Cypress Neighborhood - Room 28- 120.3 degrees F In the Juniper Neighborhood- Room 31- 120.3 degrees F In the Redwood Neighborhood- Room 43- 121.0 degrees F During interview on 9/8/16 at 3:15 PM, Building and Grounds Supervisor acknowledged the water temperature in the above resident rooms should not exceed 120 degrees F. NM 5 acknowledged water temperature above 120 degrees could	F 323	Random daily checks of the hot water temperature at the patient bathroom sinks are taken and recorded once per shift in each building. The Senior Engineer reviews the rounds sheets daily, makes the necessary adjustments to the system, and reports actions taken to the Chief Engineer. The recorded water temperatures have been below 120 degrees. Engineering Daily rounds are conducted in the North, South and Pavilion buildings by Facility Services staff and the Senior Engineer to monitor compliance with hot water temperature checks and timely follow-up. Quarterly reports from Daily rounds will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Director of Facility Services. Chief Operating Officer is responsible for reporting compliance. 2. Facility Services replaced the missing drip tray on the hand sanitizer dispenser in room N412. 3. The one bed that was identified as unlocked on South 5 Room 41 A was promptly locked for resident safety. The Nurse Manager reminded Nursing staff on South 5 to keep the resident beds in a locked positon for safety before and after completing their tasks, and before leaving the resident's room.	10/6/16 10/13/16 and on-going 9/8/16 9/6/16

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F 323	Continued From page 29 potentially cause burn injuries. She said she would make the staff aware about the elevated water temperatures in the resident rooms. Review of the facility's policy and procedure titled, "Domestic Hot Water Monitoring" dated Sept. 2015 indicated, "Policy: Watch engineers will maintain the domestic hot water temperature at a control range of 105- 120 degrees F. Purpose: To provide hot water temperature range that is safe and comfortable to the patients." 2. During environmental tour in the North 4 Tower accompanied by RN 9, EVS Director and Building and Grounds Supervisor, on 9/8/16 at 11:45 AM, a hand sanitizer dispenser attached to the wall in Room. 412 did not have a drip tray. The dispenser had an electronic sensor that dispensed the hand sanitizer when activated but some of the sanitizer dripped on the floor when tested. During an interview on 9/8/16 at 12:10 PM, RN 9 saw the hand sanitizer liquid dripped on the floor and acknowledged that it could be a risk factor for fall. She said , "It's a safety issue." 3. During initial tour in South 5 Tower accompanied by South 5 Charge Nurse on 9/6/16 at 1:25 PM, the bed of Random Resident 36 in Room. 541 B was unlocked. The resident was not in the room at this time. During a concurrent interview with South 5 Charge Nurse, she acknowledged Resident 36 was a fall risk. During an interview on 9/8/16 at 10:25 AM, Environmental Services Director stated, "Beds	F 323	A read and sign review of educational slides will be provided to neighborhood staff reminding them of the facility's safety standards including submission of a Facility Services work order when a hand sanitizer is missing the drip tray; keeping the resident's bed in a locked position to prevent risk of falls; and an automatic paging system via the Building Management System to alert the Watch Engineer and Facility Services staff when the hot water exceeds 120 degrees Fahrenheit. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Charge Nurses are assigned to conduct shift rounds on safety hazards. Nurse Managers are assigned to conduct weekly Environment of Care (EOC) rounds for safety hazards in the environment. Results of EOC rounds will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC), and bi-annually to the Performance Improvement and Patient (PIPS) Committee. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. The Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 10/13/16 and on-going

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F 323	Continued From page 30 are locked even if the resident is not in bed." Review of Random Resident 36's nursing care plan indicated she had a witnessed fall with minor injury on 8/3/16. The interventions included "Bed in lowest position and locked." Review of facility policy and procedure titled, "Electric Medical/Surgical Bed Protocol" dated May 27, 2014 indicated, "Appendix 1- Quick Reference. Operating Medical/Surgical Bed...4...d.Always apply the brakes when a resident enters and exits the bed. Apply the brakes when bed is not in transport."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	The facility has implemented policies and procedures such that each resident's drug regimen is evaluated monthly and that each resident's drug regimen is free from unnecessary drugs. The Licensed Nurse contacted Resident # 25's physician and received clarification for the use of Seroquel by providing an indication of use and target behaviors for monitoring. The resident's care plan on use of Seroquel was updated to reflect the indication of use and target behaviors for monitoring. The anti-psychotic medication orders of other residents will be reviewed by the Clinical Nurse Specialist for appropriateness of use and indication of target behaviors. The Chief Medical Officer will send a memo to physicians reminding them to include an indication of use and target behaviors when ordering anti-psychotic medications.	9/13/16 10/13/16 10/13/16

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LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF	375 LAGUNA HONDA BLVD. SAN FRANCISCO, CA 94116

(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 329	Continued From page 31	F 329	A read and sign review of educational slides will be provided to licensed nurses, physicians and pharmacists reminding them of facility standards that anti-psychotic medication orders require an indication of use and target behaviors for monitoring. The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional material.	10/13/16 and on-going

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that one of 43 sampled residents were free from unnecessary drugs when Seroquel (antipsychotic medication) was ordered for Resident 25 and there was no adequate indication for its use. The deficient practice may expose Resident 25 to the unwanted side-effects of Seroquel.

Findings:

Resident 25 was admitted to the facility on 7/18/16 with diagnoses of non-Alzheimer's dementia, depression and dementia without behavioral disturbance.

Review of Resident 25's Minimum Data Set, an assessment tool dated 7/29/16 indicated he had short term memory problem and has moderately impaired cognitive skills for daily decision making. He has physical, verbal behavioral symptoms directed towards others occurring daily and other behavioral symptoms not directed towards others.

Review of physician orders for Resident 25 indicated, "7/18/16 Seroquel 25 mg one tablet BID (twice a day)". The specific target behavior was not identified.

Review of the nursing care plan for Resident 25 indicated he was at risk for adverse effects of antipsychotic medications and has a history of

The Clinical Nurse Specialist or designee is responsible for conducting monthly Anti-psychotic Drug reviews to ensure that anti-psychotic orders are written with an indication of use and target behaviors for monitoring. Results of the monthly QA will be aggregated and submitted quarterly to the Nursing Quality Improvement Council (NQIC), Psychotropic Drug Use Sub-committee and bi-annually to the SNF Performance Improvement and Patient Safety (PIPS) Committee by the Clinical Nurse Specialist. Chief Nursing Officer is responsible for reporting compliance. — 10/13/16 and on-going

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F 329	Continued From page 32 depression. He also has diagnosis of dementia with agitation. The target behaviors were not described. Review of the monthly Behavioral Monitoring Record for August 2016 showed "...Section I: Obtain the target Behavior Symptom from the RCP (Resident Care Plan) or MD Order..." However, the staff wrote multiple target behavior symptoms: wandering/pacing, exit seeking, yelling, aggressive (pushing staff, hitting) from 8/1/16 to 8/16/16 and irritable, intrusive, sexual preoccupation from 8/17/16 to 8/31/16. These behaviors were not specified in either the resident care plan or the physician's order. During an interview on 9/13/16 at 11 AM, the Director of Pharmacy reviewed the current medication list of Resident 25 and the Assessment and Plan notes of the physician dated 8/18/16. She acknowledged that the target behavior for the use of Seroquel was not specified.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure residents were free of significant medication error when metoprolol succinate extended release tablet (a blood pressure medication) was administered not according to manufacturer's recommendation for	F 333	The facility has developed and implemented a robust Medication Error Reduction Plan. The physician assessed Resident # 37 and determined that there was no adverse effect on the resident after receiving a crushed dose of metoprolol succinate ER. 9/7/2016 The Licensed Nurse monitored Resident # 37's blood pressure and pulse rate daily for 3 days. Resident #37's blood pressure and pulse rate remained within normal limits and there were no adverse effects noted. 9/10/2016	

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F 333	Continued From page 33 Random Resident 37. This deficient practice may place Resident 37 at risk from the unwanted side-effects of metoprolol. Findings: During medication pass observation on 9/7/16, at 9:10 AM, with Licensed Vocational Nurse (LVN) 1, metoprolol succinate ER (Extended Release) 12.5 mg was crushed and administered to Random Resident 37. Record review of physician's order for Random Resident 37 indicated..."Metoprolol Succinate ER 25 mg Tablet Extended Release 24 hours, Sig (the doctor directs how much medication to take): 1/2 tablet (12.5 mg) po (per orem or by mouth) a day. Hold for systolic blood pressure less than 100 or apical pulse less than 60. Start date: 2/5/16." According to the United States Pharmacopoeia (a scientific, non-profit organization that sets federally recognized public standards of quality for medicine, dietary supplements, and foods), metoprolol succinate extended release is a beta-blocker (medication that reduce your blood pressure). It is used to treat chest pain and high blood pressure. It has been formulated to provide a controlled and predictable release of metoprolol for once daily oral administration. The tablets comprise a multiple unit system containing metoprolol succinate multitude of controlled-release pellets. Each pellet acts as a separate drug delivery unit and is designed to deliver metoprolol continuously over the dosage interval. For dosage and administration it is indicated:.."Metoprolol succinate extended-release tablets are scored and can be	F 333	The Nurse Manager re-educated LVN 1 and reminded the LVN not to crush extended release medications because the medication will lose its specialized delivery formulation for controlled continuous release. The Chief Nursing Officer sent a memo reminding Licensed Nurses that sustained or extended release medications may not be crushed and administered. A read and sign review of educational slides will be provided to licensed nurses, reminding them of the facility standard that sustained release medications may not be crushed and administered. The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional material. The Clinical Nurse Specialist and Pharmacist will conduct monthly Medication Pass Observations and will include identification of medications that are incorrectly crushed. Results of the Medication Pass Observation will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC), Medication Error Reduction Committee and to the PIPS Committee bi-annually. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC; Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	9/10/2016 9/30/2016 10/13/2016 10/13/16 and on-going

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F 333	Continued From page 34 divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed".	F 333	The Food and Nutrition Department has implemented procedures to prepare food by	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were prepared in a manner to maintain the nutritional integrity of pureed peas and in accordance with standardized recipes for six of 30 sampled residents. This had the potential to negatively impact the nutritional intake of residents receiving pureed peas. Findings: During food production observation, on 09/09/16, at 8:37 AM, the KC (Kitchen Cook) took out the prepared pureed peas in several plastic bags to place in the commercial mixer. The KC turned on the switch to automatically blend the pureed peas. After a few minutes, the KC transferred the pureed peas into a container. The KC stated he will add instant powdered potato thickener. The KC stated he did not follow the production recipe. The KC stated if he followed the recipe, the pureed peas will not achieve the right consistency.	F 364	implemented procedures to prepare food by methods that conserve their nutritive value, flavor, and appearance; and that food is palatable, attractive and at the proper temperature. The Registered Dietitian and the Food Services Manager reviewed the recipe for pureed peas and revised it to meet the desired consistency, texture and nutritional value. Other pureed recipes were also reviewed for desired consistency, texture, and nutritional value by the Registered Dietician and Food Services Manager. The decision was made to discontinue the use of heat and serve pea and corn puree, and to make these pureed items in-house. The Kitchen Cooks were provided training on preparing pureed peas according to the new recipe by the Chef and Food Service Manager and reminded not to deviate from the recipe without prior approval from the Registered Dietitian. Chefs and Food Service Supervisors will monitor meal preparation activities daily by observing staff compliance with the steps in meal preparation according to the recipe, noting the amount served, and if leftovers are discarded within the specified time. Results of monitoring activities will be aggregated monthly and reported to the Nutrition Sub-committee meeting quarterly, and to the SNF PIPS Committee meeting bi-annually. The Food Service Manager is responsible for monitoring staff compliance. The Chief Operating Officer is responsible for reporting compliance.	9/30/16 10/13/16 10/13/16 and on-going

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F 364	Continued From page 35	F 364		

During an interview on 09/13/16, at 2:55 PM, the Registered Dietician (RD) stated the KC thought the finished product of the pureed peas was too watery so he was adding instant powdered potato thickener but KC should let the chef know about this change in recipe so the chef could relay this to the food manufacturer for revision.

In an interview on 09/13/16, at 11:45 AM, the Production Chef (PC 1) stated "We ... (alter the) recipe to bring (the pureed peas to) the right consistency. Cook should report to inform the chef so that we'll call the vendor to make some changes. This was not brought to my attention."

Review of the production recipe for peas pureed dated 09/09/16, indicated, "1. place defrosted bag in steamer and heat until 170 degrees F (Fahrenheit). Approximately 1.5 hours. 2. Cut bags and place in pans for service. Cover. 3. Secure tightly with pan lid on top of plastic film. 4. When heated, utilizing a post-it, label top with the name of the content in the pans. 5. Store pans in food warmer not more than 1 hour. 6. Stir product for uniform consistency and presentation. 7. Keep warm in warming cabinet until service. 8. Serve at above 160 degrees F." There was no mention to add instant powdered potato as a thickener.

The facility policy and procedure titled "Standardize Recipes", revised date 07/09, indicated "......3. Each cook is responsible for using the appropriate recipe and returning it to the proper location. The cook must follow the recipe completely and use proper weights in recipes to insure that the desired results will be achieved.....5. Changes in Standardized Recipes may be made through the chefs if it proves to improve the quality of a food product. Changes

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F 364	Continued From page 36 are then made on CBORD system."	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store and prepare foods under sanitary conditions when: 1. Undated bags of diced potatoes and sliced zucchini were found in freezer 2 and 3. 2. The temperature in the mini-refrigerator located in Pavilion Mezzanine was above 41 degrees Fahrenheit (F). These failures did not ensure food items were stored in a sanitary manner. Findings: 1. During observation on 09/06/16, at 9:21 AM, a bag of diced potatoes in walk-in freezer 2 and a bag of sliced zucchini in walk-in freezer 3 were undated.	F 371	The facility has implemented policies and procedures for storing, preparing, distributing and serving food under sanitary conditions. 1. The bag of diced potatoes in walk-in freezer 2 and the bag of sliced zucchini in walk-in freezer 3 were discarded. Other food items stored in the Kitchen were checked for correct dating and labelling. Undated food items were discarded. Food Services staff were provided with an in-service by Chefs, Food Service Supervisors or the Food Service Manager on the importance of covering, labeling and dating of food items stored in the Kitchen. The in-service also reviewed information on how to correctly fill out the food labels, and on proper food storage using an approved container with a tight seal cover or wrap. Food Services Supervisors, Chefs and the Food Services Manager will conduct daily monitoring audits for compliance with proper covering, labeling and dating of food items in the Kitchen. Results of daily reviews will be aggregated monthly and reported quarterly at the Nutrition Sub-committee meetings, and bi-annually at the SNF PIPS Committee. Food Services Manager is responsible for compliance with monitoring activities. Chief Operating Officer will be responsible for reporting compliance.	9/6/16 9/6/16 10/13/16 10/13/16 and on-going

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F 371	Continued From page 37 During interview on 09/06/16, at 9:30 AM, the Chef Manager (CM), took out those bags in the freezer and stated the bags should be dated. The facility policy and procedure titled " Food Supply/Food Storage " revised date 01/10, indicated, " .....6. Food that is outdated, spoiled, or contaminated will be properly identified with a sign and removed from the general stores area ..... " 2. During observation on 09/06/16, at 2:15 PM, in the galley kitchen, the digital thermometer of the mini-refrigerator was registering 46 degrees Fahrenheit (°F). There were two brown bags with food items inside the mini-refrigerator. These brow bags where labeled with resident names. During record review for sensor readings on PM045 Meadow Room Nutrition Refrigerator, the plotted graph for temperature tracking dated 09/06/16 at 11:56 AM to 5:58 PM, indicated readings of above 45°F from 12:00 PM to 6:00 PM. The facility policy and procedure titled, " Wireless Refrigeration and Warming Temperature Monitoring System " revised date 01/12/16, indicated, " .....2. All refrigerators and freezers will have designated alarm settings. a .....b. nutrition refrigerator (33-41 degrees F) ... ...3. All refrigerators, freezers and blanket warmers will have alarms routed to a designated individual for responses to alarms. This will be by pager with an email/page going to a designated staff person ....Each department is responsible for notifying Facility Services of changes in the wireless refrigerator, freezer temperature, or blanket warmer monitoring system access list .....Procedure: ...3. Alarm responses	F 371	2. Facility Services staff removed and replaced the mini refrigerator located in Pavilion Mezzanine. Licensed Nurses on other neighborhoods verified the functioning of other mini refrigerators in the galley kitchens and that the temperature of the nutrition refrigerator is between 33 to 41 degrees Fahrenheit. Charge Nurses are responsible for monitoring compliance with the Wireless Refrigerator and Freezer Temperature Monitoring System (also known as Temptrak) procedures. Follow-up procedures will be revised to include an escalation alert to the neighborhood Nurse Managers when refrigerator temperature deviations outside of the established range is not resolved. Monitoring procedures will be revised to include the Watch Engineer checking the Temptrak system at the beginning of their shift to identify refrigerator temperatures that are out of range, and remain out of range. For refrigerators that have been out of range but returned to established temperature ranges, the Watch Engineer will reset the alarm system. For refrigerators that remain with temperatures outside of the established range, the Watch Engineer will check the functioning of the refrigerator and determine if the refrigerator needs to be replaced. The Chief Nursing Officer will send a memo to 24/7 Nursing staff to inform them of the changes in follow-up procedures when refrigerator temperatures are outside of established temperature ranges. A read and sign review of educational slides will be provided to Nursing and Facility services staff reminding them of the facility	9/6/16 9/6/16 10/13/16

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F 371	Continued From page 38 (Refrigerators or Freezers) a. When a designated individual receives a " refrigerator or freezer out of range alarm, it will be indicative of the temperature being out of range for 120 minutes and must be responded to within 30 minutes ...b ...c ...d.The responsible individual will go to the identified refrigerator or freezer and problem-solve the reason for an out of range alarm .... "	F 371	follow-up procedures when the licensed nurse receives a page that the refrigerator temperature is out of range. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Weekly Temptrak reports will be generated by the Clinical Informatics RN to verify monitoring and follow-up actions by the licensed nurses that they completed the following tasks:	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	1. Logged in to the Temptrak database two times a day (PM and AM Shift). 2. Acknowledged out of range refrigerator temperatures and entered information on the follow-up action taken. This report will be communicated to respective Nurse Managers to address performance or non-performance of follow-up actions when there are refrigerator temperature deviations outside of the established parameters. QA results will be aggregated by the Clinical Nurse Informatics Nurse and reported quarterly to the Nursing Quality Improvement Council (NQIC) and to the PIPS Committee bi-annually. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. Chief Nursing Officer is responsible for reporting compliance to PIPS Committee.	10/13/16 and on-going 10/13/16

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F 431	Continued From page 39 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly store medications according to facility policy and procedure when: 1. one unlabeled bottle of artificial tears was found on the bedside table of Random Resident 38; 2. one expired inhaler for Random Resident 39 was kept in the Medication Cart in North 2; 3. five tubes of prescription topical medications were found at the bedside drawer of Random Resident 40 during the initial tour on 9/6/16 on 5 South Tower; 4. one bulging bottle of hydrogen peroxide was stored in the automated drug dispensing cabinet; 5. four bags of 100 milliliters of normal saline was stored in the automated medication dispensing cabinet without the overwrap and was marked with permanent marker. Findings: 1. During observation on 9/6/16 at 11:40 AM with the Nurse Manager (NM4), one bottle of artificial	F 431	The facility has implemented policies and procedures to properly store medications. 1. The unlabeled bottle of artificial tears on the bedside table of Resident 38 was discarded. 2. The expired inhaler for Resident 39 was discarded. 3. The five tubes of prescription topical medications for Resident 40 were discarded. Pharmacy staff checked contents of all medication carts to assure no other expired medications were in the medication carts. Pharmacy staff will receive in-service training regarding performing a thorough check of all parts of the medication carts and storage areas for expired medications during monthly medication storage inspections. Pharmacy supervisor will monitor for compliance. 4. The 16 ounce bottle of Hydrogen Peroxide was returned to the Pharmacy and discarded. A report of current Hydrogen Peroxide orders was reviewed and assessed to determine that no residents was affected. All hydrogen peroxide bottles were pulled from all Omnicell cabinets and will no longer be stocked in Omnicell cabinets. Pharmacy sent hydrogen peroxide based on current orders with the appropriate patient label.	9/6/16 9/7/16 9/6/16 9/30/16 9/21/16 10/13/16 and on-going 9/8/16 9/9/16 9/9/16

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F 431	Continued From page 40 tears was found at the bedside table of Resident 38. The NM4 acknowledged the observation and stated the nurse (Registered Nurse, RN 4) left the bottle in the room. During an interview on 9/7/16 at 2:56 PM, RN 4 stated Resident 38 has a behavioral issues, it takes time to encourage him to take his medication. RN 4 stated she was interrupted during medication administration. RN 4 stated next time, "I have to ignore whatever interruptions it may be, I should pay attention (to make sure medications are not left in resident ' s room unattended)". 2) Random Resident 39 was admitted on 6/27/16 with diagnoses that include end stage kidney disease, hypertension (high blood pressure), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). During a medication storage inspection, on 9/7/16, at 9 Am, in North 2, with Acting Nurse Manager (NM) 4, a inhaler for Random Resident 39 was found in the medication cart. It had an expiration date of 5/31/16. During a concurrent interview, NM 4 acknowledged the expired inhaler prescribed for Random Resident 39 and stated it should not be in the medication cart. It should have been placed in the pharmacy pick-up box. Review of physician's order for Random Resident 39, dated 6/27/16, indicated:..." Stop ProAir HFA 108(90 Base) MCG/ACT Aerosol Solution 2 puffs using aerochamber every 4 hours as needed for wheezing, shortness of breath. Review of facility policy and procedure titled	F 431	An inservice was provided to all pharmacy staff on 9/21/16 by the Director of Pharmacy. Monthly nursing inspections by pharmacy staff will include monitoring for bulging bottles. The Supervising Pharmacist is responsible for monitoring compliance. 5. NS 100ml bags- IV fluids were removed from the Omnicell and placed in the pharmaceutical waste bin. Signs were posted in all IV fluid storage areas to notify staff of expiration dating required when iv fluid bags are removed from overwrap. Central supply created stickers that will be used to mark the date removed from overwrap, expiration date and initials of staff removing the IV fluids from the overwrap. These will be placed in each Omnicell for staff use. A sign will be posted guiding the staff to date, initial the stickers and affix to the IV fluid bags being removed from the overwrap. Pharmacy staff will add checking for presence of IV fluid bags out of overwrap without appropriate dating to the monthly unit inspection check list. Pharmacy supervisor will monitor for compliance.	9/21/16 10/13/16 and on-going 9/7/16 9/9/16 10/13/16 and on-going 10/13/16 and on-going

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"Obtaining, Handling, and Storage of Medications" revised 7/17/15, indicated..."7. Discontinued Medications: Immediately after the medication is discontinued, send or fax the order to Pharmacy, print DC on the prescription label and place the medication in the pharmacy pick-up box."

3. During initial tour on 9/6/16 on South 5 Tower accompanied by South 5 Charge Nurse on 9/6/16 at 2:10 PM, in Room. 535 A , Random Resident 40 was in bed awake , alert. His bedside drawer was partially opened and there was a basin with the following prescription topical medications: 2 tubes of Triamcinalone cream, one tube of Ketoconazole cream, one tube of Nystatin cream, and one tube of Bacitracin ointment.

During a concurrent interview with South 5 Charge Nurse, she acknowledged the Treatment Nurse should place the medications back in the treatment cart after use because it could potentially be used inappropriately."

Review of Random Resident 40's Treatment Administration Record showed the following medications:

8/17/16 Bacitracin ointment cover with optiform to left buttock skin lesion every shift until healed;
6/17/16 TAC 0.1% (Triamcinalone) oint (ointment) BID (twice a day) to back maintenance;
6/12/16 Nystatin cream to buttock area with rash q shift + prn dryness/soiling rash

Review of facility policy and procedures titled, Obtaining, Handling, and Storage of Medications dated 7/14/15 indicated, "...D. Storage of

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Medications...2. Orderliness of Medications...b. Treatment Cart: i. Ointments and creams are labeled with resident's name and are legible. All medication tubes and bottles are to have covers..."

4. During drug storage inspection on 9/7/16 at 9:50 AM with RN 6 on South 2 Tower, one unopened 16 oz. bottle of hydrogen peroxide 3% was found in the Omnicell Automatic Drug Dispensing Cabinet. The bottle was bulging and did not have an expiration date.

During a concurrent interview with RN 6, he acknowledged the bulging bottle could be an indication the hydrogen peroxide has deteriorated and should not be used.

Review of facility policy and procedures titled, Obtaining, Handling, and Storage of Medications dated 7/14/15 indicated, "...D. Storage of Medications...1. Condition of Container and Contents...b. If drug contents become outdated, contaminated, or show deterioration, return to pharmacy for replacement..."

5. During drug storage inspection on 9/7/16 at 9:50 AM with RN 6 on South 2 Tower, four IV (intravenous) bags of 100 milliliters normal saline were found stored in the Omnicell Automatic Drug Dispensing Cabinet that did not have an overwrap and was marked 9/6/16 Exp.(expiration date) 10/4/16 with a permanent marker.

During an interview with the Director of Pharmacy on 9/13/16 at 10 AM, she agreed that the IV bags should be stored with the overwrap to prevent evaporation to maintain the concentration of the

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F 431	Continued From page 43 solution and that permanent marker should not be used to label the IV solution.	F 431	The facility has a well-established Infection Control Program designed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infection.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	1. The 4 unlabeled personal care items were discarded. 2. The skin barrier ointment was discarded. 3. The soiled linen on the bathroom floor was placed in the dirty linen hamper for wash. 4. The undated oxygen tubing on S3 14B and S343B were replaced and the tubing change was documented on the Treatment Administration Record of respective residents. Charge Nurses and Nurse Managers were instructed to conduct rounds on their respective neighborhoods to identify similar conditions described in No. 1 through 4 that may be occurring on the neighborhoods and to implement corrective actions as per facility standards. The Chief Nursing Officer sent a memo on the revised Nursing Protocol for dating and labelling oxygen tubing. A read and sign review of educational slides will be provided to neighborhood staff reminding them of the facility's infection control standards for items 1 through 4, including the new protocol for dating and labelling oxygen tubing. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material.	9/6/16 9/6/16 9/6/16 9/6/16 9/6/16 10/13/16

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F 441	Continued From page 44 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure adequate infection control practices when: 1. Four unlabeled personal care items (a can of shaving cream, a container of deodorant, a comb and a razor) were found in N 324's shared bathroom. Failure to label personal care items in shared bathrooms may increase the risk of cross contamination between residents. 2. One unlabeled skin barrier ointment was found in N 224's shared bathroom. Failure to label personal care items in shared bathrooms may increase the risk of cross contamination between residents. 3. Soiled linens were found on the bathroom floor in N 235. This failure did not ensure this was a sanitary environment. 4. Undated Oxygen tubings were found in rooms S 314 B and S 343 B. These failure had the potential to place residents at risk for infection. Findings: 1. During initial tour observation on 9/6/16 at 9:25 AM, in room N324's shared bathroom, the following unlabeled personal care items were found on the sink: a container of shaving cream, a container of roll on deodorant, a comb and a	F 441	Charge Nurses will conduct daily environmental rounds that includes checking on the proper labelling of resident personal items, linen handling, and labelling and dating of oxygen tube changes every 24 hours. Results of the Charge Nurse daily environmental rounds will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC), and bi-annually to the Performance Improvement and Patient (PIPS) Committee. Nursing Program Directors are responsible for monitoring reporting compliance to NQIC. The Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee. Quarterly Infection Control rounds will be conducted by the Infection Control Nurse and findings reported to Nurse Managers for follow-up and corrective actions. Nursing Program Directors are responsible for monitoring completion of corrective actions and reporting to NQIC as necessary.	10/13/16 and on-going 10/13/16

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razor. The above observation was confirmed with Nurse Manager (NM) 6 during the initial tour. During a concurrent interview, NM 6 stated since this was a shared bathroom, these care items should be labeled with a resident name.

2. During observation on 9/6/16 at 11:35 AM, in room N224's bathroom, an unlabeled skin barriers ointment was found on the top of the sink and Nurse Manager (NM4) confirmed the observation. During a concurrent interview, NM4 stated this care item should not be stored in the common area unlabeled.

3. During observation on 9/6/16 at 12:10 PM, in room N 235's bathroom, soiled linens were found on the floor. During a concurrent interview the NM4 stated these soiled linens should not be placed on the floor.

4. During the initial tour of third floor South Tower (S3) on 9/6/16 at 1:50 PM, accompanied by the Nurse Manager (NM) 2, Random Resident (RR-42) was asleep in bed using an oxygen via nasal cannula with undated tubing. NM 2 stated, "we don't label (oxygen tubing), we document." The NM 2 explained it was the night shift staff's responsibility to change the oxygen tubing on a daily basis and document it in the Treatment Record.

Review of the Face Sheet indicated RR 42 was admitted to the facility on 1/28/15. The Physician's Order, dated 8/1/16, indicated an order on 6/8/15 for oxygen at 2-3 liters /minute via nasal cannula for comfort.

In a follow-up interview on 9/6/16 at 2. 32 PM, NM

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F 441	Continued From page 46 2 searched the clinical record and the "binder" (where the Treatment Record forms were kept for all residents using oxygen) but failed to find the Treatment Record document for the month of September, 2016. After searching, NM 2 acknowledged there was no record that oxygen tubing changed everyday since the beginning of the month, "they (staff) must have missed it". The NM 2 stated a new form for September, 2016 Treatment Record would be started. Continued tour of S3 with the NM 2 on 9/6/16 at 2:02 PM., in room S 343-B, the oxygen tubing was at "2 liter" /minute, it was undated. In a follow up interview on 9/6/16 at 2:25 PM. NM 2 searched the entire record and acknowledged there was no documentation anywhere in the record that the oxygen tubing was changed since the beginning of September, 2016. The NM 2 stated a new September, 2016 Treatment Record would be started. Record review of facility policy and procedure. Oxygen Administration , File:1 5.0, July, 2016. ... Procedure: ...G. All disposable oxygen administration devices shall be replaced every 24 hours. Daily, the AM shift licensed nurse will change all disposable oxygen devices, including but not limited to: ... connecting tubings, nasal cannula or catheter, ... Documentation of the replacement shall be noted in the resident's treatment sheet..	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care	F 456	The facility is equipped with a functioning communication, both audible and visual, system that includes nurse stations capable of receiving resident calls from resident rooms, toilets and the shower/bathing areas. The facility also has a wireless system that connects the call light system to portable (Spectralink) telephones carried by Nursing staff.	

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F 456	Continued From page 47 equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe operation of zone light for nurse call light system for 8 out of 48 households (South 5 Marina, Buenavista, Sierra, South 6 Sierra, Buenavista, Marina, Pacifica, and South 2 Marina). This deficient practice could potentially result in delayed responses to residents call lights. Findings: During observation on 9/8/16 at 1:12 PM, at South 5 (S5) Marina household, Nursing Director (ND 1) pressed the bedside call light in Room 22. The zone light located at the end of the corridor did not light up. During a concurrent interview, ND 1 stated the light "should always show." At 1:33 PM, at S5 Buenavista household, ND 1 pressed the bedside call light at Room 513. The zone light did not light up. At 1:37 PM, at S5 Sierra household, ND 1 pressed the bedside call light at Room 44. The zone light did not light up. At 1:44 PM, at South 6 (S6) Sierra household, ND 1 pressed th bedside call light at Room 45. The zone light did not light up. At 1:46 PM, at S6 Buenavista household, ND 1 pressed the bedside call light at Room 11. The zone light did not light up.	F 456	Facility services staff replaced the light bulbs of zone lights on South 5 (Room 13 Buena Vista, Room 22 Marina, and Room 44 Sierra households); South 6 (Room 45 Sierra, Room 11 Buena Vista, Room 35 Pacifica and Room 24 Marina households) and South 2 (Room 21 Marina household) and the zone lights now light up when the call light button is pressed in the respective rooms listed. The Clinical Informatics Nurse verified that Nursing staff continue to receive the call light alert when the call light is activated even if the zone light do not turn on. The call light communication system remained functional when the call light is activated and sends the alert to the strobe outside the resident's room, to the master station, and to spectralink phones so there is no disruption of the call light system and nursing staff continue to be able to receive resident calls for assistance. Nursing staff on other neighborhoods were instructed to verify that zone lights in the other households light up when the call light is tested, and to complete a Facility Services work order if the zone light does not light up. A read and sign review of educational slides will be provided to Nursing and Facility services staff reminding them of facility standards to maintain a fully functioning call light system and the necessary corrective actions. The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional material.	9/8/16 9/8/16 9/9/16 10/13/16

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F 456	Continued From page 48 At 1:47 PM, at S6 Marina household, ND 1 pressed the bedside call light at Room 24. The zone light did not light up. At 1:50 PM, at S6 Pacifica household, ND 1 pressed the bedside call light at Room 35. The zone light did not light up. ND 1 acknowledged all the findings. At 2:09 PM, at South 2 (S2) Marina household, Nurse Manager (NM 1) pressed the bedside call light at Room 21 bedside call light. The zone light at the end of the corridor did not lit up. NM 1 acknowledged the findings.	F 456	PCAs and CNAs are assigned to conduct daily call light checks in resident rooms and weekly checks of the bathroom and shower areas. This includes verifying that the light outside of the resident rooms turn on as well as the zone lights at the end of the household in the South and North Towers. Charge Nurses are responsible for monitoring compliance. Nurse Managers are responsible for conducting resident check in's once a month. The check in's will include assessing proper functioning of the resident call light as part of the quality assurance (QA) monitoring. Nursing Program Directors are responsible for monitoring compliance.	10/13/16 and on-going 10/13/16 and on-going
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a functioning communication system from the resident rooms and toilets when the call system on South 4 Tower had shut down on 9/6/16. The deficient practice could potentially result to fall, injury and failure to meet the residents' needs because the residents' did not have a means to call for assistance. Findings:	F 463	Results of the call light monitoring activity will be reported to NQIC every quarter and to the SNF PIPS Committee bi-annually. Nursing Program Directors are responsible for reporting compliance to NQIC. Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee. The call light malfunction on South 4 was resolved at approximately10:30am on 9/6/16. South 4 neighborhood was on downtime procedures between 8:09 am to 10:30 am. The Nurse Manager made frequent rounds and conducted resident check in's to ensure that resident needs are met. Hospital investigation revealed that the call light malfunction was due to failure of the central power supply box.	10/13/16 and on-going 9/6/16 9/6/16

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F 463	Continued From page 49 During initial tour on 9/6/16 at 9:10 AM, accompanied by Nurse Manager 10, Nursing Director (ND) 1 and RN 8, the resident in Room 411 A was asked to press her call light to test it. A flashing white light (dome light) was turned on in the hallway just outside the resident's room but there was no audio reception in the room. The call lights of Room 411B and 411C and the bathroom call lights were also tested with the same result. The NM 10 and ND 1 were unable to explain why or when the call light started to malfunction. RN 8 said she called Patient care Assistant 1 from Clinical Informatics to check on the call light that morning because the CNAs noticed that the lights in the hallway turned green when they tested the call lights. During an interview with PCA 1 on 9/6/16 at 9:30 AM, he said that the call lights were not functioning in the Pacifica neighborhood and the Stationary Engineer was notified about the problem. During an interview on 9/6/16 at 9:50 AM, the Stationary Engineer explained that the power supply had shut down affecting all the call lights on the South 4 nursing unit. He said the Central Processing Unit (CPU) offline needed to be replaced to restore the power supply. The work would be completed in 10 minutes. During interview on 9/6/16 at 10 AM, Nursing Director 1 stated the shutdown started at 8:09 AM that morning.	F 463	Facility Services staff replaced the central power supply box. The call light system was fully restored as soon as the central power supply box was replaced. Restoration of the call light system would have been achieved sooner if Facility Services staff was contacted earlier, as soon as the call light malfunction was detected. The Clinical Informatics Nurse contacted Charge Nurses on other neighborhoods on the South Tower, North Tower and Pavilion building and verified that the call light system were fully functional on the remaining neighborhoods. The central power supply box on other neighborhoods were checked and found to be functional. The Chief Nursing Officer sent a memo to 24/7 Nursing staff on call light downtime procedures, including immediate actions to be taken and managing such scenarios to maintain resident safety and meeting resident needs. Nursing Services support staff and Nursing Education will conduct monthly system downtime drills. The drill will include a call light system downtime scenario to maintain staff proficiency in managing downtime system procedures. A QA tool will be used to assess staff proficiency in responding to downtime procedures. Results of the monthly System Downtime Drills will be aggregated, and reported quarterly to NQIC and bi-annually to the PIPS Committee. Nursing Program Directors are responsible for reporting compliance to NQIC. The Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	9/6/16 9/6/16 9/6/16 10/13/16 10/13/16 and on-going

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F 463	Continued From page 50 During an interview with RN 8 on 9/6/16 at 11:45 AM, she stated she was aware that there was a problem with the call lights that morning in the Pacifica and Marina neighborhood. She did not notify the Nursing Manager. She acknowledged that there was no alternate method provided to allow residents to call for help if needed in the absence of a functioning call system. Review of facility policy and procedure titled, "Nurse and Resident Call System" dated July 2016 indicated, "Policy:...10. All bedside call lights must be checked daily, and shower and bathroom call lights must be checked weekly for proper function...Procedures: ...B...Checking Function of Resident Call System...4. Reporting of NonWorking Resident Call System a. Report to Facility Services if the nursing staff is unable to hear a call to or from the Master Station, Patient Call Station, Patient Pillow Speaker, Adaptive Nurse Call Devices, or from Spectralink phone..."	F 463		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the building was free of insects when: 1. Two flies were observed circling around	F 469	The facility contracts the services of a pest control company to maintain an effective pest control program so that the facility is free of pests and rodents. 1. An Environmental services work order was submitted to rid Resident 22's room of flies. Environmental services staff performed mechanical cleaning and treatment to floor drains, disposals, and other sources of fruit fly larva to prevent the emergence of new adult fruit flies in Resident 22's room and surrounding areas. The contracted vendor for pest control installed fly traps to catch adult flies on the neighborhood including Resident 22's room.	9/20/16
			2. An Environmental services work order was submitted to rid Resident 33's room of flies. Nursing services provided Resident 33 with sealed containers to the store perishable food that resident wished to keep at bedside. Environmental services staff performed mechanical cleaning and treatment to floor drains, disposals, and other sources of fruit fly larva to prevent emergence of new adult fruit flies in Resident 33's room and surrounding areas. The contracted vendor for pest control installed fly traps to catch adult flies on the neighborhood including Resident 33's room.	9/20/16

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F 469	Continued From page 51 Resident 22's face in resident room; 2. a dozen flies were observed on and around containers of opened perishable foods in Resident 33's room; 3. nine fruit flies were observed in N 315's bathroom; 4. several fruit flies were seen near the drainage area where the two commercial mixers were located in the kitchen. Failure to implement an effective pest control program had the potential to subject residents to an unsanitary environment. Findings: 1. During observation on 9/8/16 at 10:50 AM, two flies were observed flying around the face of Resident 22. During a concurrent interview, Resident 22 stated, "I sometimes see flies in my room and it sucks because I can't do nothing about it". 2. During observation on 9/6/16 at 12:30 PM, there were multiple items of spoiled perishable food with flies in Resident 33's room. These items included but were not limited to: a plastic container with sandwich covered in white, black and green substance, two open containers of lemon wedges with flies, and an open container of sliced peaches with flies and a brown mug with liquid residue and flies. During a concurrent interview, Charge Nurse (CN1) stated "There are a lot (of flies), I think we have counted about twelve" . 3. During initial tour observation on 9/6/16 at 10:35 AM, nine fruit flies were found on room N 315's bathroom wall. In a concurrent interview to Nurse Manager (NM 6) she acknowledged the	F 469	3. An Environmental services work order was submitted to rid N315's bathroom of flies. Environmental services staff performed mechanical cleaning and treatment to floordrains, disposals, and other sources of fruit fly larva to prevent emergence of new adult fruit flies in room N315 and surrounding areas. The contracted vendor for pest control installed fly traps to catch adult flies on the neighborhood including Room 15. 4. An Environmental services work order was submitted to rid the Kitchen of flies. Environmental services staff performed mechanical cleaning and treatment to floor drains, disposals, and other sources of fruit fly larva to prevent emergence of new adult fruit flies in the Kitchen. The contracted vendor for pest control installed fly traps to catch adult flies in the Kitchen. The contracted pest control vendor will perform initial weekly visits for 4 weeks, followed by monthly visits for maintenance treatment of primary sources of flies until the flies are eradicated on South 6, North 1, North 3 and the Kitchen. Charge Nurses and Nurse Managers on other neighborhoods were instructed to check their respective neighborhoods for the presence of flies and to submit an Environmental services work order if the neighborhood had a problem with flies. Plastic food containers will be provided to residents to store food at bedside. For maintenance treatment, the 13 neighborhoods and other non-residential floors will be inspected every 2 months by the contracted pest control vendor to identify potential secondary sources of flies.	9/20/16 9/20/16 9/20/16 10/13/16 and on-going 9/13/16 10/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555020	A. BUILDING _____ B. WING _____	09/13/2016

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F 469	Continued From page 52 presence of fruit flies. Review on facility policy titled " Environmental Services Policy and Procedures " , dated 6/10, indicated " ...To provide a pest free, clean, healthy environment for residents, staff and visitors... The environmental Services Department will provide Nursing Department with a pest control service schedule for all nursing units. Nursing units will be treated once every two (2) months." 4. During food production observation on 09/09/16, at 8:37 am, there were 6 moving small fruit flies, in the drainage area where the two commercial mixers were located. During interview with PC 2 (Production Chef) on 09/09/16, at 8:45 am, PC 2 stated "Someone came in yesterday to get rid of those fruit flies but still were present."	F 469	A read and sign review of educational slides will be provided to neighborhood and Kitchen staff. Staff will be reminded on facility standards for maintaining a sanitary and pest free environment that includes prompt reporting when flies are first observed on the neighborhood and Kitchen areas, and further involves collaboration with Environmental, Nursing, and pest control vendor services. The Nurse Educator is responsible for developing the educational slides. Managers are responsible for monitoring staff compliance with review of the instructional material. Charge Nurses will conduct daily environmental of care rounds to include observations for the presence of pests (such as flies) on the neighborhoods. Results of Daily Environmental of Care Rounds by Charge Nurses will be aggregated and reported quarterly to the Nursing Quality Improvement Council (NQIC) and to the PIPS Committee bi-annually. Nursing Program Directors are responsible for monitoring quarterly reporting compliance to NQIC. Chief Nursing Officer is responsible for reporting compliance to the PIPS Committee.	10/13/16 and on-going 10/13/16 and on-going
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to train one housekeeping staff on how to respond during a fire emergency. Failure to ensure staff were knowledgeable regard fire emergencies may place residents at risk of	F 518	The facility trains employees in fire emergency procedures when they begin work in the facility; provide annual fire safety in-services for current staff; and carry out unannounced fire drills every month.	

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F 518	Continued From page 53 injuries during a fire emergency. Findings: During an interview on 9/6/16, at 1:40 PM, with housekeeper (HK) on what to do if the fire alarm rings, the HK stated, "I will pull the alarm, tell the nurse, help the resident, use the fire extinguisher, and excavate." Review of facility policy and procedure titled "Fire Response Plan" indicated..."Procedure: 1. When You See Smoke or Fire a. Follow the R.A.C.E. acronym for basic fire response steps: i. Rescue persons in immediate danger while announcing "Code Red" to nearby staff. ii. Alarm by continuing to shout "Code Red" to nearby staff and by activating the alarm using the nearest manual pull station. iii. Contain the smoke and/or fire by closing all windows and doors. iv. Extinguish the fire only when it is safe to do so. Otherwise Evacuate.	F 518	The Environmental Services Supervisor reviewed the facility's fire safety procedures with the housekeeper who was interviewed, going over Code Red procedures including the acronym R.A.C.E. (Rescue, Alarm, Contain, Extinguish) and P.A.S.S. (Pull, Aim, Squeeze, Sweep); and reminding the staff involved to refer to his badge buddy in case of a momentary lapse in recalling the facility's fire emergency procedu A read and sign review of educational slides will be provided to facility staff reminding them of the facility's fire emergency procedures. The Nurse Educator is responsible for developing the educational slides. Department Managers are responsible for monitoring staff compliance with review of the instructional material. Fire safety drills are conducted by the Facility Services Safety Engineer monthly, including quarterly on every shift, at unexpected times under varying conditions. Neighborhood staff including Environmental services staff are involved in fire drills. Facility Services staff assigned to conduct fire drills has been trained to review the Fire Drill Participation forms and analyze staff responses for completeness and if review criteria are met. Nurse Managers, Nurse Educators, the Safety Engineer and Industrial Hygienist periodically quiz random staff members on staff ability to respond to fire emergency procedures. Quarterly reports from fire drills will be submitted to the Performance Improvement and Patient Safety (PIPS) Committee biannually by the Director of Facility Services. Chief Operating Officer is responsible for reporting compliance.	9/13/16 10/13/16 10/13/16 and on-going