STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056120	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EMPRES POST ACUTE REHABILITATION	300 DOUGLAS STREET PETALUMA, CA 94952

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and a review of resident medical records, the facility failed to properly obtain consent for (a) the administration of [MEDICAL CONDITION] drugs for four residents (33, 78, 84 and 85); (b) the administration of an influenza vaccine for one resident (84); (c) implementation of Physician order [REDACTED]. These failures had the effect of violating the rights of these residents to be informed of the risks, benefits and alternatives of treatment decisions prior to receiving those treatments, or (if these residents did not have the capacity to make their own decisions) to have a Responsible Party be informed on their behalf. Findings: In a 3/11/20 review of Resident 33's medical record, it was identified that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. not real); obsessive-compulsive disorder (a mental health condition with symptoms of excessive orderliness, perfectionism and attention to detail); and developmental delay (a mental or physical development delay that is not normal for the person's age and affects speech, movement and thinking ability). In a [DATE] 9:30 a.m. review of Resident 33's medical record, there was no evidence of an informed consent having been obtained from the resident's Responsible Party for administration of the anti-psychotic drug, [MEDICATION NAME]. (Anti-psychotic drugs affect the chemicals in the brain and are used to treat behavioral conditions like [MEDICAL CONDITION] and dementia. [MEDICAL CONDITION] is a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality. Dementia is a chronic or persistent disorder of the mental processes caused by brain disease or injury and is marked by memory disorders, personality changes, and impaired reasoning.) In an interview on 3/11/20 at 4:22 p.m., Administrative Staff L was asked if there were any unfiled consents in the Medical Records Department for Resident 33's [MEDICATION NAME] administration. In an interview on 3/13/20 at 11:50 a.m., the Director of Nursing and the Assistant Director of Nursing, both stated that a signed informed consent for [MEDICATION NAME] for Resident 33 had not been located in either Resident 33's medical record or in the Medical Records Department. A document was observed in Resident 33's medical record that was titled, [MEDICAL CONDITION] Drug and Behavior Review Form - Quarterly and PRN. Dated 2/8/19, the form listed [MEDICATION NAME] as a medication being administered to Resident 33. Under the column which stated Consent Y/N (Consent Yes/No), neither Y nor N was checked for consent presence. A second copy of this document, dated 4/23/19, had neither Y nor N checked for consent presence for [MEDICATION NAME]. A third copy of this document, dated 8/1[DATE]9, listed the generic name of [MEDICATION NAME], [MED], but Y is checked for consent presence (in error, since no consent form could be located). A fourth copy of this document, dated 12/13/19, had neither Y nor N checked for presence of a consent for [MEDICATION NAME]. A facility policy titled, Informed Consent for [MEDICAL CONDITION] Drugs - [ST] Only (updated 9/17), stated in the Policy Statement section, When the physician has ordered the use of Anti-Psychotic.Drug, the Physician.obtains informed consent from the resident or responsible party. An informed consent is obtained before the drug prescribed is administered at the Center. A document titled, Order Summary Report - February 28, 2020, indicated that Resident 33 began receiving the medication [MEDICATION NAME] on 3/11/18, despite not having a signed consent from her Responsible Party to receive this medication. In an interview with the Director of Nursing (DON) on 3/11/20 at 9:24 a.m., the DON stated that [MEDICAL CONDITION] drugs were not to be administered unless the signature of a Responsible Party was present (in the event the resident lacked his/her own decision-making capacity). In a 3/11/20 review of Resident 84's the medical record, it was identified that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. blood effectively through the body); [MEDICAL CONDITION] (a narrowing of the blood vessels of the heart); major [MEDICAL CONDITION] (a condition characterized by a persistent feeling of sadness and loss of interest in one's surroundings); and non-[CONDITION] dementia (a condition characterized by impaired judgment, slowness, difficulty planning and organizing tasks and some degree of memory loss.) On [DATE] at 10:00 a.m., a document was observed in Resident 84's medical record that was titled, Order Summary Report - Active Orders as of [DATE]. On Page 3 of 4 of this document, the following statement was present: Resident has capacity to understand choices and make healthcare decisions: NO. This entry was dated 2/9/19. This form was signed by Resident 84's physician and dated 3/3/20. On [DATE] at 10:00 a.m., a document was observed in Resident 84's medical record that was titled, [MEDICAL CONDITION] Drugs Disclosure and Consent - [ST] Only. The consent was for the administration of 15 mg of the medication [MEDICATION NAME]. (The abbreviation mg stands for milligrams, a unit of measurement.) This consent, signed by the physician and dated 2/10/20, was also signed by Resident 84, who dated the consent 120-20-20. However, it had been previously determined that Resident 84 lacked the capacity to give informed consent or make medical decisions for herself due to her medical condition. On [DATE] at 10:10 a.m., a second document was observed in Resident 84's medical record that was titled, [MEDICAL CONDITION] Drugs Disclosure and Consent - [ST] Only. The consent was for the administration of 15 mg qd of the medication [MEDICATION NAME]. (The abbreviation qd stands for every day.) This second consent was not signed by the resident's Responsible Party. It was only signed by Resident 84's physician and was not dated. A facility policy titled, Informed Consent for [MEDICAL CONDITION] Drugs - [ST] Only (updated 9/17), stated in the Policy Statement section, When the physician has ordered the use of Anti-Psychotic.Drug, the Physician.obtains informed consent from the resident or responsible party. An informed consent is obtained before the drug prescribed is administered at the Center. A document titled, Order Summary Report - February 28, 2020, indicated that Resident 84 was administered the medication [MEDICATION NAME] beginning 1/31/20, despite no authorized consent having been obtained from Resident 84's Responsible Party to do so. On [DATE] at 10:15 a.m., a document was observed in Resident 84's medical record that was titled, Physician order [REDACTED]. (A POLST provides guidance to healthcare providers regarding a resident's wishes for treatment at the end of life or in the event of a medical emergency.) The POLST was signed by Resident 84 on 11/13/18. However, it was previously determined that Resident 84 lacked the capacity to give informed consent or make medical decisions for herself due to her medical condition. On [DATE] at 10:15 a.m., a document was observed in Resident 84's medical record that was titled, Influenza Vaccine Informed Consent. The consent was signed by Resident 84 and dated 9/12/19. Elsewhere in this record it was identified that the influenza vaccine was administered to Resident 84 on 10/22/19. However, it had been previously determined that Resident 84 lacked the capacity to give informed consent or make medical decisions for herself due to her medical condition. On [DATE] at 10:00 a.m., a document was observed in Resident 84's medical record that was titled, Device Informed Consent. This was a consent to initiate a Wanderguard device on Resident 84, so she would be able to walk around within the facility. (A Wanderguard is a device worn by a resident that triggers an alarm should the resident attempt to leave the facility through an alarm-activated door.) The medical reason listed for use of the device was, Poor impulse control and dementia (dementia is a chronic or persistent disorder of the mental processes caused by brain disease or injury and is marked by memory disorders, personality changes, and impaired reasoning). The consent was signed by Resident 84 and dated 60/17/19. However, it had been previously determined that Resident 84 lacked the capacity to give informed consent or make medical decisions for herself due to her

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

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In a 3/11/20 review of Resident 85's medical record, it was identified that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].); [MEDICAL CONDITION] (a chronic mental illness that impairs thoughts and behavior and can lead to hallucinations and disorganized thinking); developmental delay (mental or physical development that is not normal for the person's age and affects, speech, movement and thinking); and [MEDICAL CONDITION]. On [DATE] at 10:20 a.m., a document was observed in Resident 85's medical record that was titled, Order Summary Report - Active Orders as of [DATE]. On Page 3 of 5 of this document, the following statement was present: Resident has capacity to understand choices and make healthcare decisions: NO This was dated 10/16/18. Another document in the record, titled Encounter - Nursing Home Visit Date of Service 11/13/18 and written by Resident 85's physician, stated, on page 5 of 5, Decision Making Capacity: Without. In a [DATE] 10:15 a.m. review of Resident 85's medical record, a document titled, [MEDICAL CONDITION] Drugs Disclosure and Consent - [ST] Only, indicated Disclosure of the Risks and Benefits regarding the use of [MEDICAL CONDITION] Drugs. This was a consent form for the medication [MEDICATION NAME] 1 mg. ([MEDICATION NAME] is the brand name for the medication [MEDICATION NAME], and is given to treat anxiety, a condition where feelings of worry, nervousness, or unease are present. The abbreviation mg stands for milligrams, a unit of measurement.) The consent had not been signed by Resident 85's Responsible Party. The consent was signed only by Resident 85's physician and was undated. In a [DATE] 10:20 a.m. review of Resident 85's medical record, a document titled, [MEDICAL CONDITION] Drugs Disclosure and Consent - [ST] Only, indicated Disclosure of the Risks and Benefits regarding the use of [MEDICAL CONDITION] Drugs. This was a consent form for the medication [MEDICATION NAME] ([MEDICATION NAME]) 150 mg. ([MEDICATION NAME] is the brand name and [MEDICATION NAME] is the generic name for a medication used to treat depression. Depression is an illness characterized by a persistent feeling of sadness and loss of interest in one's surroundings.) The consent had not been signed by Resident 85's Responsible Party. The consent was signed only by Resident 85's physician and was undated. In a [DATE] 10:22 a.m. review of Resident 85's medical record, a document titled, [MEDICAL CONDITION] Drugs Disclosure and Consent - [ST] Only, indicated Disclosure of the Risks and Benefits regarding the use of [MEDICAL CONDITION] Drugs. This was a consent form for the medication [MEDICATION NAME] 20 mg. ([MEDICATION NAME] is the brand name and [MEDICATION NAME] is the generic name for this medication that is used to treat certain mental/mood conditions such as [MEDICAL CONDITION], a chronic mental illness that impairs thoughts and behavior and can lead to hallucinations and disorganized thinking.) The consent had not been signed by Resident 85's Responsible Party. The consent was signed only by Resident 85's physician and was undated. In a [DATE] 10:22 a.m. review of Resident 85's medical record, a document titled, [MEDICAL CONDITION] Drugs Disclosure and Consent - [ST] Only, indicated Disclosure of the Risks and Benefits regarding the use of [MEDICAL CONDITION] Drugs. This was a consent form for the medication [MEDICATION NAME] 2 mg. ([MEDICATION NAME] is the generic name for a medication that affects chemicals in the brain and is used to treat behavioral conditions like [MEDICAL CONDITION]. The consent had not been signed by Resident 85's Responsible Party. It was signed only by Resident 85's physician and was undated. Also observed was a second copy of this form, which was a consent for [MEDICATION NAME] 2 mg BID. (The abbreviation BID means twice a day.) This second consent was signed by Resident 85 and dated 5/5/17. However, it had already been determined that Resident 85 lacked the capacity to make medical decisions for herself due to her medical condition. Facility policy titled, Informed Consent for [MEDICAL CONDITION] Drugs - [ST] Only (updated 9/17), stated in the Policy Statement, When the physician has ordered the use of Anti-Psychotic.Drug, the Physician.obtains informed consent from the resident or responsible party. An informed consent is obtained before the drug prescribed is administered at the Center. This policy was violated when (a) Resident 85 was administered [MEDICATION NAME] without the informed consent of Resident 85's Responsible Party and (b) when she was allowed to sign her own consent when it had been determined that she lacked the capacity to make healthcare choices and medical decisions for herself. Resident 78's Medication Administration Record [REDACTED]. ([MEDICATION NAME] is the brand name of a medication used to treat certain mental/mood conditions such as [MEDICAL CONDITION], a chronic mental illness that impairs thoughts and behavior and can lead to hallucinations and disorganized thinking.) However, no informed consent document was found in the record to indicate that Resident 78 (or a Responsible Party) had given the consent for this medication dosage change. In an interview with the Director of Nursing (DON) on 3/13/20 at 11:50 a.m., the DON acknowledged (a) the forms without dates (of physician orders/entries) and (b) improper management of consents and stated, We've identified there are opportunities for improvement.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise and update nursing care plans when: 1. One of six sampled residents (Resident 13) suffered a fall at the facility, and his revised care plan did not include permanent effective interventions to prevent further falls, and; 2. One of six sampled residents (Resident 71) had a care plan that did not match her physician orders. These failures could have resulted in further falls with possible injuries to Resident 13, and lack of compliance with physician orders [REDACTED]. Findings: 1. Resident 13 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. A facility document titled, SBAR Communication Form, dated 2/10/20, indicated Resident 13 suffered a fall on 2/08/10. According to this document, Resident 13 was found sitting on the floor facing the hallway, by the bedside. A skin tear was noted in his left arm. No other injuries were noted. The long-term care plan for falls initiated on 10/03/19 was revised after the fall on 2/08/20, but only included the following new intervention, POC (Plan of care) Reviewed *Labs. This intervention did not indicate what labs were going to be taken, and whether or not the labs were going to be obtained periodically at specific intervals. Prior to this fall on 2/08/20, Resident 13 had suffered two other falls at the facility, according to his care plans for falls. One fall occurred on 12/01/19 and another on 12/03/19. During an interview on 3/12/20 at 11:32 a.m., the Director of Staff Development (DSD) confirmed labs could prevent falls, if the fall was due to a medical disease or condition captured by labs, but it was not a permanent solution unless labs were done on a schedule, therefore it was not an effective permanent intervention to prevent further falls. A request was made to the Director of Nursing (DON) on 3/12/20 for a policy on care planning. The DON provided the policy requested but it only included information on baseline care plans. The policy, published in January of 2019 indicated, A baseline plan of care is developed and provided to each Resident and/or his/her Representative, following admission. The policy did not address comprehensive, person centered care plans, after 48 hours of admission. Neither did it address the need to revise or update care plans as needed based on a resident's change of condition. The facility policy titled, Fall Evaluation (Morse Scale) and Management, last updated in March of 2018, indicated, The Center implements a fall management plan based on medical history review and resident evaluation .Post-Fall Documentation: 1. After the resident has been evaluated and cared for and appropriate notifications have been made, the licensed nurse: f. Reviews and updates the care plan with newly identified interventions, as needed. During a record review on [DATE] at 11AM, Resident 71's Face Sheet indicated, Resident 71 was a long term, dependent resident, admitted on [DATE]. Resident 71's [DIAGNOSES REDACTED]. The record indicated a BI[CONDITION] (Brief interview for mental status to assess resident's attention, orientation, and ability to recall information) of 9 During a record review on [DATE] at 10:30 a.m., Emergency Department Report dated [DATE] indicated, the facility sent the Resident 71 to the hospital for left knee pain. X-ray (picture of inside of knee) was completed and indicated Resident 71 had left fractured knee cap. Resident 71 was fitted and placed in a knee immobilizer and returned to the facility. During an interview on [DATE] at 11:20 a.m., Administrative Staff B stated Resident 71 was a fall risk due to her tremors and uneven gait. Since her left knee fracture it was even harder for her to ambulate with the knee immobilizer and since she was non weight bearing on the left leg she is traveling by wheel chair only. During a record review on [DATE] at 11:15 a.m., Resident 71's, Physical

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Therapy Progress Notes, dated [DATE] indicated, Resident 71 had an MD order to start Physical Therapy. During a record review on [DATE] at 11:30 a.m., Resident 71's knee care plan had been marked as being resolved the same day it was started on 1/9/20. Review of Resident 71's clinical record indicated, on [DATE] there was a knee immobilizer (brace that stops the knee from bending) and Physical Therapy ordered but neither were on the care plan. During an interview on 3/11/20 at 9AM, Nursing Staff K stated there are no further care plans that address Resident 71's knee orders after returning from the emergency department. Nursing Staff K stated her tremors are worse now and she only travels by wheelchair. During an interview on 3/11/20 at 10:10 am, Resident 71 was alert to name and place. Resident 71 stated, I do not get help getting into my chair and they never come to help me when I call. When asked about her knee brace she responded they never help me put it on and I can't walk alone. During a concurrent interview and record review, on 3/12/20, at 11:09 a.m., in the conference room Administrative Staff G stated, I will be the first to tell you that the facility's care planning is a work in progress and we are aware of what we need to improve upon. When she was shown Resident 71's knee care plan dated 1/9/20 and resolved 1/9/20, Administrative Staff G stated, the word resolve should have never been written on that care plan off to the side like that. Instead, that care plan should have been updated to include the post emergency visit orders. When Administrative Staff G was asked if there was another care plan that included Resident 71's post emergency visit orders she stated, no. She said the knee care plan dated 1/9/20 should have been revised to include the multidisciplinary team such as physical therapy, the resident representative notification, and the CNA (certified nursing assistance). Resident 71 needed more assistance with activities of daily living and transfer assistance due to none weight bearing on the left leg. Administrative G was shown Resident 71's care plan dated 1/9/20 where it had one goal which stated, will have 0 complications. Underneath that goal were pre-printed re-evaluation boxes to be checked as they were reassessed and dated every 30 days, 60 days and 90 days. These boxes were blank. Administrative Staff G stated the goal was not acceptable and the boxes should have been filled in as part of the care plan revision. During an interview on 3/17/20 at 12PM the Public Guardian (court appointed decision maker for Resident 71) stated she was aware that Resident 71 had been seen in the emergency dept. for left knee pain and was diagnosed with [REDACTED]. Review of the facility's policy and procedure titled, Base Line Plan of Care, dated 1/2019 indicated, the facility developed and provided a plan of care to each resident or their representative that included directives for promoting safe delivery of care. The document indicated nursing provided continuous evaluations and reassessments in response to the patient's changing needs.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 11) received her scheduled baths. This failure had the potential to result in discomfort, body odor, and increased risk for infection. Findings: Resident 11 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. During an observation on [DATE] at 8:52 a.m., Resident 11 was in bed, and appeared to be sleeping. Resident 11 was unable to be interviewed due to her declining health. Resident 11's hair appeared greasy and soiled. Small whitish particles of what appeared to be dead skin cells or dandruff were visible on Resident 11's scalp. Resident 11 was wearing a gown and otherwise, appeared clean. An interdisciplinary note dated 2/11/10 indicated Resident 11 received only bed baths due to her medical status, as her health was declining due to [MEDICAL CONDITION] with [MEDICAL TREATMENT]. A nursing care plan on self-care deficit initiated on 3/04/20 indicated, Shower, as scheduled or bed bath .Assist c (with) all hygiene. The facility's shower schedule last updated on 4/2[DATE]9, indicated Resident 11 was scheduled for a bath twice a week on Tuesdays and Fridays. A facility document titled, RESIDENT FUNCTIONAL PERFORMANCE RECORD, dated 3/20, indicated Resident 11 had received no bed baths/showers or tub baths from 3/01/20 to 3/13/20. Staff had documented N/A (Not applicable) for baths, on most shifts (Some boxes were left blank), in the section titled, BATHING. This document indicated, Indicate type of bath provided in lower box of SP. *T=Tub, S=Shower, B=Bed Bath. During an interview on 3/13/20 at 11:50 a.m., Unlicensed Staff N and Unlicensed Staff O, who were in the room with Resident 11, confirmed there was no documentation in the RESIDENT FUNCTIONAL PERFORMANCE RECORD indicating Resident 11 had received any bed baths or showers from 3/01/20 to 3/13/20. Unlicensed Staff N stated some nursing assistants did not know how to document bed baths, and instead documented, NA which meant Not applicable. Unlicensed Staff O stated nursing assistants were frequently in serviced on documenting activities of daily living correctly. During an interview on 3/13/20 at 12:08 p.m., the Director of Staff Development (DSD) confirmed documentation in the RESIDENT FUNCTIONAL PERFORMANCE RECORD did not provide evidence showing that Resident 11 received any bed baths or showers from [DATE] to 3/13/20. The DSD stated nursing assistants received training on clinical documentation requirements. The DSD also stated personnel from Medical Records were responsible for auditing residents' medical records. During an interview on 3/13/20 at 2:19 p.m., Administrative Staff L, Medical Records Coordinator, stated she had no clinical experience, and while she audited other medical records, she had not been checking the RESIDENT FUNCTIONAL PERFORMANCE RECORD which included documentation on activities of daily living, such as baths. The education nursing book titled, Clinical Nursing Skills SEVENTH EDITION, by F. Smith, D. Duell and B. Martin, published in 2008 indicated, Routine bathing is an essential component of daily care. It is essential to prevent body odor, because excessive perspiration interacts with bacteria to cause odor. Dead skin cells can lead to infection if impaired skin integrity occurs .Relaxation and improved circulation are benefits of bathing and play a therapeutic role in the care of clients on bedrest (pg. 175).
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of accidents/hazards when: 1. Resident 92, who had suffered three falls at the facility, and was care planned to receive one-to-three oversight (Supervision of one staff to three residents), was left alone in her room for an undetermined period of time, and; 2. Eight of sixteen sampled and unsampled residents (Resident 5, Resident19, Resident 8, Resident 58, Resident 42, Resident 40, Resident 45, and Resident 33), at high risk for falls, were not included in a program initiated by the Director of Nursing, for staff to identify residents at high risk for falls. This failure had the potential to result in further falls with fractures, and possible death, to the facility residents at risk for falls. Findings: 1. Resident 92 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. First Fall: A fall short-term care plan initiated on 1/27/20 indicated Resident 92 suffered a fall with no injury at the facility on 1/27/20. The care plan indicated, No injury lost balance while ambulating. Second Fall: A fall short-term care plan initiated on 2/7/20 indicated Resident 92 suffered a fall on 2/7/20 at the facility, which resulted in compression fractures. This was corroborated by a discharge summary (A document that outlines the details of the hospitalization of a patient) from an acute care facility dated [DATE] at 6:28 p.m., which indicated Resident 92 had a fall at the facility on 2/7/20 and suffered vertebral fractures at the level of T12 (The twelfth [MEDICATION NAME] vertebra in the spine), L2 (Second lumbar spinal vertebra, within the lower back) and L3 (Third lumbar spinal vertebra, within the lower back) as a result of the fall. Third Fall: A facility document titled, IDT (Interdisciplinary) FALL REVIEW, dated [DATE] indicated Resident 92 suffered a fall at the facility on [DATE]. The discharge summary of the acute care facility where she was transferred, indicated Resident 92 suffered a left humerus (Long bone that extends from the shoulder to the elbow) fracture as a result of the fall on [DATE]. A care plan for alteration in safety for Resident 92, initiated on [DATE] and revised on [DATE] (After Resident 92's fall on [DATE]), indicated, IDT review [DATE] 1/3 oversight (One-to-three oversight). A fall risk care plan for Resident 92, initiated on [DATE], indicated, One to one oversight (Supervision of one staff to one resident) reeval (Reevaluate) as needed. One care plan indicated Resident 92 was required to receive one-to-three oversight while the other care plan indicated Resident 92 was required to receive one-to-one oversight. During an observation on 3/11/20 at 2:51 p.m., Resident 92 was noted to be in bed, with no staff present in the room or in the hallway supervising her. Resident 92's curtain was partially covering her bed, which made it impossible to see her from the nursing station. It was unknown for how long Resident 92 was left alone prior to this observation. At 2:53 p.m. a nursing assistant (Unlicensed Staff O) came to supervise Resident 92 and stood in the hallway. When asked why Resident 92 was left unsupervised, Unlicensed Staff O stated she was standing in the hallway, which was not observed. Unlicensed Staff O later stated she was receiving an in-service at the nursing station but another

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) nursing assistant (Unlicensed Staff N) was assigned to supervise Resident 92. Unlicensed Staff N was interviewed and confirmed she was supervising Resident 92 earlier, but stated the assignment was handed over to Unlicensed Staff O. When asked if she notified Unlicensed Staff O that she was handing over the assignment of supervising Resident 92, Unlicensed Staff N confirmed she did not. During an interview on 3/11/20 at 3:02 p.m., Resident 92's assigned nurse, Nursing Staff J stated that the staff supervising Resident 92 had to be in the room with Resident 92 to make sure she did not suffer another fall. He confirmed Resident 92 could not be observed from the nursing station, as her curtains were partially covering her bed, where she was laying. During an interview on 3/13/20 at 10:36 a.m., the Director of Nursing (DON) stated Resident 92 was under one-to-three oversight. The DON stated staff was highly encouraged, not to leave the Resident 92's room when Resident 92 was inside, and stated staff was encouraged to find other staff to replace them if they were to leave Resident 92's room. When asked for their policy on one-to-one supervision and one-to-three oversight, the DON stated they did not have one. The DON was asked if they had a written description of these types of supervision, to which the DON replied they did not. The DON stated staff was verbally instructed about one to three oversight. 2. A document provided by facility management dated 3/09/20, indicated sixteen residents had suffered falls at the facility. According to this document, three had suffered falls with injuries. During an interview on 3/11/20 at 1:40 p.m., Nursing Staff J was asked how they identified residents at high risk for falls. Nursing Staff J stated he would have to find out. Five minutes later, at 1:45 p.m., Nursing Staff J stated they had a form on the residents' Medication Administration Record [REDACTED]. The Director of Nursing (DON) was present, and mentioned a board, which was part of a new program they had initiated to prevent falls, which was posted on the employee break room that also included the names of the residents at high risk for falls, for staff awareness. During an interview on 3/11/20 at 2:59 p.m., Nursing Staff J stated he had worked at the facility for about ten years and prior to the interview on 3/11/20 at 1:40 p.m., did not know about the form listing the residents at high risk for falls which was filed in the Medication Administration Record. During an interview on 3/12/20 at 2:32 p.m., Nursing Staff P was asked how she identified residents at risk for falls. Nursing Staff P mentioned the board that listed the residents at high risk for falls, posted in the employee breakroom. Nursing Staff P did not mention the list filed on the Medication Administration Record. During observation on 3/12/20 at 2:35 p.m., in the employee breakroom, a board titled, HIGH RISK FALL RESIDENTS, listed the following residents: 1. Resident 39 2. Resident 92 3. Resident 143 4. Resident 73 5. Resident 87 6. Resident 28 7. Resident 13 8. Resident 71 These same residents were listed on the undated document titled, Alert-This list is High risk for Falls, filed in the residents' Medication Administration Record. A document provided by facility management dated 3/09/20, listed the following residents as having fallen at the facility but were not on the list of residents at high risk for falls, in the Medication Administration Record [REDACTED]. A facility document titled, MORSE FALL SCALE (A scale used by the facility for assessing a patient's likelihood of falling) dated 12/0[DATE]9, indicated Resident 5 received a score of 65. The document indicated, Fall Scoring: High Risk 45 and higher. 2. Resident 19 The undated facility document titled, IDT FALL REVIEW, indicated Resident 19 suffered a fall on 2/06/20. Resident 19's MORSE FALL SCALE dated 3/11/20 indicated she received a score of 50, placing her at high risk for falls. 3. Resident 8 A facility document titled, IDT FALL REVIEW, dated 12/09/19 indicated Resident 8 suffered a fall on 12/08/19. Resident 8's MORSE FALL SCALE dated [DATE] indicated she received a score of 50, placing her at high risk for falls. 4. Resident 58 A facility document titled, IDT FALL REVIEW, dated 1/09/20 indicated Resident 58 suffered a fall on 1/08/20. Resident 58's MORSE FALL SCALE dated 1/08/20 indicated she received a score of 55, placing her at high risk for falls. 5. Resident 42 A facility document titled, IDT FALL REVIEW, dated 9/19/19 indicated Resident 42 suffered a fall on 9/17/19. Resident 42's MORSE FALL SCALE dated3/07/20 indicated he received a score of 55, placing him at high risk for falls. 6. Resident 40 A facility document titled, IDT FALL REVIEW, dated 11/12/19 indicated Resident 40 suffered a fall on 11/10/19. Resident 40's MORSE FALL SCALE dated 1/3/20 indicated he received a score of 75, placing him at high risk for falls. 7. Resident 45 A facility document titled, SBAR Communication Form, dated 11/21/19 indicated Resident 45 suffered a fall on 11/21/19. Resident 45's MORSE FALL SCALE dated 1/06/20 indicated she received a score of 55, placing her at high risk for falls. 8. Resident 33 A facility document titled, IDT FALL REVIEW, dated 12/18/19 indicated Resident 33 suffered a fall on 12/17/19. Resident 33's MORSE FALL SCALE dated 12/29/19 indicated she received a score of 105, placing her at high risk for falls. During an interview on 3/13/20 at 10:29 a.m., the DON was asked the reason for including only some high risk patients on the list in the Medication Administration Record [REDACTED]. The DON stated it was based on a decision taken by the interdisciplinary team (IDT) based on each resident's individual risk. She was asked to provide evidence of IDT meetings that would show the excluded residents at high risk for falls were discussed and chosen not to be on the list. The DON was unable to provide evidence. An undated document titled, High Risk Fall Prevention Best Practice, provided by the DON on 3/13/20 at 10:29 a.m., indicated, Staff will be alerted to high risk for fall residents. The facility policy titled, Fall Evaluation (Morse Scale) and Management, last updated in March of 2018 indicated, If the total Morse Scale score is greater than 45, the resident is considered as having High Potential for falls. Implement appropriate care plan interventions for fall management .Post-Fall Documentation: After the resident has been evaluated and cared for and appropriate notifications have been made, the licensed nurse: e. Updates the Morse Scale. f. Reviews and updates the care plan with newly identified interventions as needed.
F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and a review of facility records, the facility failed to ensure that attending physicians consistently dated their orders, as required by facility policy. Fifteen orders for five residents (Residents 33, 78, 84, 85, 94) were undated. Undated orders could lead to confusion as to the timing when orders are expected to take effect and could potentially compromise resident medical management and and compromise resident health and well-being. Findings: The attending physician did not date the following eleven forms , all titled, [MEDICAL CONDITION] Drugs Disclosure and Consent: (a) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent, for [MEDICATION NAME] 15 mg qd for Resident 84 was signed by the physician but was not dated. ([MEDICATION NAME] is a medication used to treat depression, a condition characterized by persistent feelings of sadness and a loss of interest in one's surroundings; the abbreviation mg means milligrams, a unit of measure for medications; qd is an abbreviation that means every day.) (b) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent, for 1 mg [MEDICATION NAME] for Resident 85 was signed by the physician but was not dated. ([MEDICATION NAME] is the brand name of a medication used to treat anxiety.) (c) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 1 mg q 12 hrs for Resident 85 was signed by the physician but was not dated. (Lorazapam is the generic name for [MEDICATION NAME], a medication used to treat anxiety; q is an abbreviation that means every; hrs is an abbreviation that means hours.) (d) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] ([MEDICATION NAME]) 150 mg for Resident 85 was signed by the physician but was not dated. ([MEDICATION NAME] is the brand name and [MEDICATION NAME] is the generic name of a medication used to treat depression.) (e) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 150 mg for Resident 85 was signed by the physician but was not dated. ([MEDICATION NAME] is the generic name of a medication used to treat depression.) (f) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 20 mg for Resident 85 was signed by the physician but was not dated. ([MEDICATION NAME] is a medication that affects chemicals in the brain and is used to treat behavioral conditions like [MEDICAL CONDITION], which is a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.) (g) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 2 mg for Resident 85 was signed by the physician but was not dated. ([MEDICATION NAME] is the generic name for a medication that affects chemicals in the brain and is used to treat behavioral conditions like [MEDICAL CONDITION].) (h) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 2 mg bid for Resident 85 was neither signed nor dated by the physician. It was signed by the resident on 5/5/17. ([MEDICATION NAME] is the generic name for a medication that affects chemicals in the brain and is used to treat behavioral conditions like [MEDICAL CONDITION]; bid is an abbreviation that means twice a day.) (i) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 2 mg bid for Resident 85 was signed by the physician but was not dated. It was signed by the resident's Responsible Party on 7/28/19. (j) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 20 mg for Resident 85 was signed by the physician but was not dated. It was also signed by the resident's Responsible Party on 7/28/19. ([MEDICATION NAME] is another medication that affects chemicals in the brain and

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	056120	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EMPRES POST ACUTE REHABILITATION	300 DOUGLAS STREET PETALUMA, CA 94952

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F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) is used to treat behavioral conditions like [MEDICAL CONDITION].) (k) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 2.5 mg qd for Resident 85 was signed by the physician but was not dated. It was also signed by the resident's Responsible Party on 7/28/19. ([MEDICATION NAME] is another medication that affects chemicals in the brain and is used to treat behavioral conditions like [MEDICAL CONDITION]; qd is an abbreviation that means every day.) (l) A form titled, [MEDICAL CONDITION] Drugs Disclosure and Consent for [MEDICATION NAME] 10 mg two times a day for Resident 78 was initialed by the resident on 8/[DATE]6. Resident 78's physician initialed the consent but did not date it. ([MEDICATION NAME] is a medication that affects chemicals in the brain and is used to treat behavioral conditions like [MEDICAL CONDITION], which is a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.) In addition to the above twelve items, a seven-page form titled Order Summary Report (for Resident 33), for Active Orders as of [DATE], was signed by the physician but was not dated. A document titled Note to Attending Physician/Prescriber, was sent to the physician by a consultant pharmacist (on 1/28/20) who requested an order for [REDACTED]. A document titled Note to Attending Physician/Prescriber, was sent to the physician by a consultant pharmacist (on 2/18/20) who requested an order for [REDACTED].) The physician checked the box No Change, signed the order, but did not date it. A facility policy titled, Physician Visits (dated 2/2008) stated, under section 3. a.,Orders have physician's signature and are dated. The facility did not follow its own policy. In an interview with the Director of Nursing (DON) on 3/13/20 at 11:50 a.m., the DON acknowledged (a) the forms without dates (of physician orders/entries) and (b) improper management of consents and stated, We've identified there are opportunities for improvement.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently ensure expiration dates were on opened medication bottles, expired medications were discarded, and residents' personal medication had their names on the label. These failures could potentially lead to staff administering expired medications or treatments to residents, or potentially administering the wrong medication to a resident. Findings: A tour of the facility's Medication Storage Room, on [DATE], at 2:45 p.m., indicated some medications and over-the-counter items were expired. These included: 1. A bottle containing packing for wound treatment, with an expiration date of 10/2019. 2. A bottle labeled, Mucus Relief, with an expiration date of 1/2020. During a concurrent interview, the Director of Nursing, DON, and Assistant Director of Nursing, ADON, verified both bottles were expired. 3. One Foley catheter, used to insert in an individual's bladder for urination, did not have an expiration date. In a concurrent interview, the DON verified that it did not have an expiration. During an inspection of Medication Cart #3, on 3/11/20, at 3 p.m., the following medication items were not labeled with resident names and identifiers, were expired or discontinued: 1. Eye gel, labeled Systal, had a room number, but did not have resident's name on the bottle and the box in which it came had a room number, 124B, but not the resident's name. During a concurrent interview, when asked what happened if a resident was transferred from one room to another room, and a new resident admitted to 124B, Nursing Staff J indicated she understood that without a resident's name, nursing staff could mistakenly administer one residents medications to another. 2. A liquid form of a diabetic medicine, [MEDICATION NAME], did not have either the resident's room number or name on the label but did have the resident's name inside the box in which the medication originally came. During a concurrent interview, when asked what happened if the bottle was separated from the box, Nursing Staff J indicated she understood the box could potentially be separated from the bottle, and bottle unidentified. 3. A medication container had an oral antibiotic medicine,[MEDICATION NAME], with multiple tablets left. In a concurrent interview, Nursing Staff J stated, the resident was discharged to the hospital approximately 5 days ago . I don't know why this medication was not removed. When asked what's your policy when opening a medication?, Nursing Staff J stated, we don't have any Policy for dating. Nursing Staff J stated, I agree the name of resident and an open date should be labeled on the medication container. Nursing Staff J stated, it was not part of our training.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of facility documents, the facility did not ensure food was stored in accordance with professional safety standards, when the facility kitchen's walk-in refrigerator contained 7 expired sandwiches. This failure had the potential to place residents at risk for food borne illness. Findings: During an observation and kitchen tour, on [DATE], at 9:30 AM, the walk-in refrigerator contained four peanut butter and jelly sandwiches and 3 cheese sandwiches with used-by dates of [DATE]. During an interview on [DATE], at 9:40 AM, Administrative Staff F stated the four peanut butter and jelly sandwiches and the 3 cheese sandwiches should never have been placed in the refrigerator because they were yesterday's snacks and should have been discarded on [DATE]. He stated placing expired items in the refrigerator could potentially expose residents to food a borne illness. During a review of the facility's policy and procedure titled, Food Storage revised ,[DATE], it indicated, Items that have use by dates indicated on them should be discarded prior to that date.
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** Based on interview and record review, the facility did not have policies for medication storage and labeling, clinical documentation requirements, one-to-one supervision (Supervision of one staff to one resident), comprehensive care planning, and one-to-three oversight (Supervision of one staff to three residents), which was implemented for three of six sampled residents for safety (Resident 143, Resident 92 and Resident 11). This failure had the potential to result in lack of guidance for competent care, inadequate nursing services, and lack of compliance with state and federal regulations. Findings: A request was made to the Director of Nursing (DON), and Administrative Staff G several times throughout the survey, starting on 03/09/20 at 3:12 p.m., for the following facility policies, which would have contained guidance for deficiencies found during the annual recertification survey: 1. Medication Storage & Labeling 2. Clinical Documentation 3. One-to-One Supervision 4. One-to-Three Oversight 5. Comprehensive Care Planning During an interview with the DON and Administrative Staff G on 03/13/20 at 10:10 a.m., they stated not having the policies requested above. They provided a care planning policy, but the policy only contained information on baseline care plans, and did not cover comprehensive care planning for residents. The policy did not cover requirements for care plan revisions or updates. The DON and Administrative Staff G confirmed having three residents (Resident 143, Resident 92 and Resident 11) on one-to-three oversight but stated not having a policy or written document describing this type of supervision.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical documentation was complete and accurate when: 1. A nursing assistant documented the amount of food consumed by a resident (Resident 41), at risk for nutritional deficiencies, inaccurately in the medical record, 2. The POLST (Physician order [REDACTED]. legal document providing instructions as to the type and degree of medical care to be administered in the event that the person signing the document becomes incapacitated), 3. Nursing notes were not timed for one of six sampled residents (Resident 143) These failures

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	056120	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EMPRES POST ACUTE REHABILITATION	**300 DOUGLAS STREET PETALUMA, CA 94952**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) could have resulted in inability for the interdisciplinary team and clinicians to obtain a picture of the residents' progress, including their response to treatments and services, changes in their condition, plan of care goals, objectives and interventions. Findings: 1. Resident 41 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. A facility document titled, WEIGHT RECORD, indicated Resident 41 had refused to have her weight taken since 9/10/19 until the present, but her last documented weight taken on 9/0[DATE]9 was 80 pounds. The facility's winter menu, indicated that on 3/09/20 for lunch, residents received, SPAGUETTI SAUCE WITH MEAT BUTTERED SPAGUETTI TOSSED SALAD DRESSING GARLIC BREAD ICE CREAM COFFEE OR TEA MILK GARNISH. During an observation on 3/09/20 at 12:50 p.m., Resident 41 was observed in bed. Her lunch tray was sitting on top of her bedside table, which Resident 41 had pushed away. Resident 41 stated she was done eating. It was observed that Resident 41 only ate the spaghetti, which accounted for one third of the food on her plate. Resident 41 left the other two entrees on her plate (Garlic bread/spaghetti sauce with meat and salad in pureed form) untouched, as well as her dessert. She drank half a cup of water, which accounted for approximately 60 ml of fluid. Resident 41 stated the meal was salty, and she would not eat the rest. During an observation on 03/09/20 at 1:05 p.m., Resident 41's tray was taken away by Unlicensed Staff Q. A facility document titled, MEAL MONITOR FLOWSHEET, for March of 2020, indicated Resident 41 consumed 60% of her lunch on 3/09/20 and ingested 240 milliliters of fluid. This was documented by Unlicensed Staff Q. This document had an area for alternate percentage, which was documented as N (no), and an area for MD (Medical Doctor) ordered supplements, which was documented as N (no). During an interview on 3/11/20 at 9:35 a.m., Unlicensed Staff Q confirmed Resident 41 had only eaten the spaghetti on her tray on 3/09/20 for lunch, but stated Resident 41 had drank a supplement, brought by her son, at around 10:30 that morning, so she counted the supplement as 40% of Resident 41's lunch meal. Unlicensed Staff Q stated she counted the spaghetti on Resident 41's tray as 20 % of her lunch meal, so by adding up the supplement plus the spaghetti, she documented Resident 41's meal consumption as 60% on 3/09/20 for lunch. Unlicensed Staff Q was asked if she had been provided training indicating supplements were to be counted as 40% of a resident's meal, to which Unlicensed Staff Q stated she had not. Unlicensed Staff Q stated she assumed the supplement was 40% of a meal. During an interview on 3/11/20 at 10:30 a.m., Administrative Staff I, Registered Dietician, stated if Resident 41 had only eaten spaghetti from her tray, that would be considered 15-20% of the meal. Administrative Staff I stated supplements were not to be included with the lunch meal percentage. Administrative Staff I also stated if a resident ate less than 50%, the nursing assistant was supposed to offer something to the resident, which could be a supplement. A facility document titled, Guidelines for Food Intake-Lunch and Dinner, last updated in February of 2015, indicated the pasta portion of a meal accounted for 10% of the meal. This document indicated, If 50% or less of meal is consumed, offer alternate menu items. If alternate is not accepted, offer a supplement. Document % consumed. 2. A facility document titled, Physician order [REDACTED]. Resident 65 2. Resident 143 3. Resident 13 4. Resident 11 5. Resident 7 6. Resident 41 Section D of the POST asked if the resident had an Advanced Directive, did not have an Advanced Directive or the Advanced Directive was not available. All three questions were left blank in the residents' POLST listed above. During an interview on 3/12/20 at 9:00 a.m., Administrative Staff C, Social Services Director, stated all areas of the POLST were required to be filled out. She stated that initially, the physician went over the form with the residents upon admission, and during the first interdisciplinary meeting for each resident, the POLST was audited for completeness. She confirmed that assuming residents did not have Advanced Directives because they could not be located on the residents' medical records was not a good idea, and stated the POLST needed to be complete in regards to Advanced Directives. She confirmed the POLST for the above clients, were filled out at the facility. 3. Resident 143 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. A nursing note for Resident 143, dated 2/25/20, with no time documented, indicated, V/s (Vital signs) refused. Resident (Resident 143) was brought at 6:18 pm from (Acute Care Facility). Based on the information contained in the note, this appeared to be an admission nursing note. A physician progress notes [REDACTED]. S/P (status [REDACTED]. A second nursing note dated [DATE], with no time documented, indicated, I was endorsed from Noc (Night) shift and reported that Resident (Resident 143) had fall @ (at) 0645 (6:45 a.m.). I had quickly went into the room and found Resident in a upright position yelling in pain and found left low extremity in abducted (An extremity moved away from the midline of the body) position. The note was dated but did not include the time when it was documented, and instead indicated, AM (A.m. shift). During a concurrent interview and record review on 3/11/20 at 9:58 a.m., the Director or Nursing (DON) confirmed the nursing notes on 2/25/20 and [DATE] were not timed, but stated these notes were summaries of the shifts, and did not have to be timed. During an interview on 3/12/20 at 10:10 a.m., Administrative Staff G, Regional Nurse Consultant, stated that absolutely, all nursing notes had to be timed, and stated that although they did not have a specific policy on it, they followed Lippincott (Online source for evidence-based procedure guidance in nursing) practices, and Lippincott stated licensed nurses should time their entries. The DON was asked for a policy on clinical documentation on 3/11/20 at 10:30 a.m. and 03/12/20 at 08:50 a.m. The DON stated she could not find one on 3/12/20 at 8:50 a.m., but provided an undated document published by the National Committee of Quality Assurance (Nonprofit organization that works to improve health care quality) titled, Guidelines for Medical Record Documentation, which indicated, Consistent, current and complete documentation in the medical record is an essential component of quality patient care.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed proper infection control practices when: 1) Nursing Staff P's hair contaminated her sanitized hands, residents' medications, and a cup of juice for resident comsumption. 2). Vital signs equipment was not sanitized before use. Findings: 1. During an observation while on initial tour of the facility on [DATE]20, Nursing Staff P's hair was not tied away from her face while passing medication. During a medication pass observation on 3/11/2020 at 11:30 a.m., Nursing Staff P sanitized her hands before preparing medication. Nursing Staff P's hair touched her sanitized hands. Nursing Staff P poured juice into a plastic cup, her hair strand touched the opening of the juice cup and the medication cup containing medications. The Director of Nursing (DON) approached Nursing Staff P while preparing medication and stated You are doing fine. The DON did not comment that Nursing Staff P's hair was not tied away from her face. A review of Policy and Procedure titled Personal Appearance and dress code updated April 2007 indicated that all employees report to work appropriately dressed and well groomed. On page 48, under Personal Appearance and Behavior, #5 indicated, Employees involved in direct resident care must have long hair secured away from their faces. A review of the Policy and Procedure titled Infection Control Policies and Practices published in May 2015 indicated, This Facility infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Under Procedure: #2 indicated, The objectives of our infection control policies and practices are to: Prevent, detect, investigate and control infections in the facility. #4, All Personnel are trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and pertinent procedures and equipment related to infection control. A review of the document titled Licensed Staff Orientation Checklist dated 10/4/2006, submitted by the Director of Staff Development (DSD) indicated that Infection Control was not one of the topic discussed during the Staff Orientation. 2). During an observation on 3/09/20 at 10:11 a.m., essential vital signs equipment was observed in one of the facility's hallways, exposed and unattended, for an undetermined amount of time. The equipment was charging from an electrical outlet. A few moments later, at 10:15 a.m., Unlicensed Staff M was observed taking the vital signs equipment, and entering a residential room with it. Unlicensed Staff M proceeded to take vital signs on Resident 92, which included putting a blood pressure cuff around Resident 92's partially uncovered arm, without disinfecting the equipment prior to the task. After taking vital signs on Resident 92, Unlicensed Staff M was observed disinfecting the equipment and using it on another resident. During an interview on 3/09/20 at 10:23 a.m., Unlicensed Staff M confirmed not having disinfected the vital signs equipment prior to using it on Resident 92. During an interview on 3/12/20 at 11:18 a.m., with the Director of Staff Development (DSD), she stated vital signs equipment left charging in the facility's hallways had to be disinfected prior to using it on residents. The facility policy titled, Cleaning and Disinfecting Environmental Surfaces, last revised in May of 2015, indicated, Non-critical items are those that come in contact with intact skin but not mucous membranes .Non-critical surfaces are disinfected with an EPA (Environmental protection agency)-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions .Intermediate and low-level disinfectants for

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) non-critical items include: Ethyl or [MEDICATION NAME] alcohol; Sodium hypochlorite (A chlorine compound often used as a disinfectant).