STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INLAND VALLEY CARE AND REHABILITATION CENTER	**250 W. ARTESIA STREET POMONA, CA 91768**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to answer the call lights promptly and provide resident assistance for six out of 35 sampled residents (Resident 40, 50, 89, 39 , 144 and 43). This deficient practice had the potential for the residents care needs will not be met promptly that could affect the residents health and well being. Findings: a. A review of Resident 39's Admission Record indicated he was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 39's MDS, dated [DATE], indicated he had no cognitive impairment, required extensive assistance with bed mobility, transfers, dressing, toilet use and ADLs. During the Resident Council Meeting, on 3/4/20, at 10:15 a.m., Resident 39 stated there was a call light issue. He stated CNAs play a game where they will answer call lights, but said they were not the CNA assigned to them and tell residents their CNA was busy and canceled their call lights. Resident 39 stated he waited 30 minutes to one hour for his urinal because staff placed the urinal not within reach, for example, the urinal was in the bathroom. Resident 39 stated CNAs were on their phone while he was calling for help. b. A review of Resident 40's Admission Record (Facesheet) indicated she was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/14/19, indicated she was cognitively (a mental action of acquiring knowledge and understanding) intact, required supervision with ADLs, limited assistance with mobility and extensive assistance with toileting. During the Resident Council Meeting, on 3/4/20, at 10:15 a.m., Resident 40 stated sometimes we have to wait for 45 minutes for the call light to be answered. c. A review of Resident 50's Admission Record (Facesheet) indicated she was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 50's MDS, dated [DATE], indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required total assistance with activities of daily living, eating and toileting. During an interview, on 3/3/20, at 10:21 a.m., Resident 50 stated he had to wait for staff between 45 min and one hour every day. He stated he had soiled his diaper waiting for staff. d. A review of Resident 89's Admission Record (Facesheet) indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 89's MDS, dated [DATE], indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, she required extensive assistance with activities of daily living and toileting. During the Resident Council Meeting, on 3/4/20, at 10:44 a.m., Resident 89 stated she waited a long time to get help and she has had bathroom accidents waiting for staff. She stated she was moved to a different room and the call light did not work and she did not know it. She stated she hollered for the staff to help her and nobody came. e. A review of Resident 144's Admission Record (Facesheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 144's MDS, dated [DATE], indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required extensive assistance with activities of daily living and an ostomy, requiring total assistance with toileting. During the Resident Council Meeting, on 3/4/20, at 10:44 a.m., Resident 144 stated he had a [MEDICAL CONDITION] bag and sometimes he waited so long for assistance his [MEDICAL CONDITION] bag starts seeping and it when it gets so full it burst. He stated he waited a long time to get help and he had soiled himself waiting for staff. He stated residents ask for services, for example, dressing changes and needs to ask multiple staff because it was not being done. He stated he waited a long time to be put to bed. A record review of the facility's policy and procedure (P&P), revised 11/2016, titled, Call System, indicated answer call bells promptly, always be courteous when responding to a request for assistance, listen to resident's request and do not make him/her feel that you are too busy to help, respond to request, return to resident. f. A review of the admission record for Resident 43 indicated resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. end of the spinal cord and disrupt motor and sensory function to the lower extremities and bladder). A review of the minimum data set (a standardized assessment and care screening tool) dated 12/17/19, indicated Resident 43 has the ability to make self understood and understand others. The MDS indicated Resident 43 is totally dependant on staff for transfer to or from bed and toilet use. Resident 43 required extensive assistance from staff for dressing and personal hygiene, and limited assistance for bed mobility. During an interview with Resident 43 on 3/03/20 at 9:05 a.m., Resident 43 stated call lights were not answered on time specially during 11p.m. to 7a.m. shift. Resident 43 stated he had to wait 30 sometimes 45 minutes before somebody came to answer the call light. Resident 43 further stated 7a.m. to 3p.m. shift was okay, the 3p.m. to 11p.m. shift was getting bad, and 11p.m. to 7a.m. shift was the worst. During an interview with Licensed Vocational Nurse 3 (LVN 3) on 3/09/20 at 6:56 a.m., LVN 3 stated that call lights should be answered right away. LVN 3 stated that answering call lights was everybody's responsibility. LVN 3 stated that he worked the night shift (11a.m. to 7p.m.) and stated that there were 30 residents in his unit and 2 certified nursing assistants (CNAs) assigned for the night shift. During an interview with the Director for Nursing (DON) on 3/09/20 at 1:22 p.m., DON stated that residents' call lights were everybody's responsibility. DON stated that call lights should be answered within four to five minutes. A review of the facilities policy and procedure for Call Lights, dated revised on November 2016, indicated that it is the facility's policy to provide each residents with the call system to enable them to request assistance, and it is the policy of the facility to answer call bells promptly.
F 0577 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on interview and record review, the facility failed to ensure residents knew the location of the most recent survey results for five out of 35 randomly sampled residents (Resident 5, 38, 39, 144 and 161). This deficient practice had the potential for the residents will have no knowledge of the survey results that could affect their quality of care and well being. Findings: During the resident council meeting, on 3/4/20, at 10:15 a.m., five out of 13 residents stated they did not know the survey results could be viewed or where the survey results binder was located. A record review of the facility's policy and procedure (P&P), revised 4/2007, titled, Survey Results, Examination Of, indicated a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ringbinder located in an area frequented by most residents, such as the main lobby or resident activity room. The facility's policy did not indicate the facility's responsibility to ensure residents are informed the state survey results are available for review.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**

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

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Advance Directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) education or information was provided and documented on the facility's Advance Directive Acknowledgement Form for seven out of 35 residents (Resident 30, 40, 50, 91, 129, 138 and 149). This deficient practice had the potential for the residents' treatment wishes not to be carried out in the event the residents' were unable to communicate or during an emergency. Findings: a. A review of Resident 30's Admission Record (Facesheet) indicated she was readmitted on [DATE] with [DIAGNOSES REDACTED]. both lungs). A review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/22/20, indicated she was cognitively (a mental action of acquiring knowledge and understanding) intact and she had no Advance Directive. A record review of the POLST, dated 2/15/20, signed by Resident 30's responsible, indicated she did not have an Advance Directive and no Advance Directive Acknowledgement Form was found in the clinical record. During an interview and concurrent record review, on 3/9/20, at 12:08 p.m. with the social services assistant/designee (SSA) the Advance Directive Acknowledgement Form was not found in the clinical record for Resident 30 indicating the responsible party was informed about Resident 30's Advance Directive rights. b. A review of Resident 40's Admission Record (Facesheet) indicated she was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/14/19, indicated she was cognitively (a mental action of acquiring knowledge and understanding) intact and an Advance Directive was not completed. A record review did not indicate if Resident 40 had an Advance Directive and no Advance Directive Acknowledgement Form was found in the clinical record. During an interview and concurrent record review, on 3/6/20, at 7:48 a.m., with the director of nurses (DON) she stated I don't see it. She stated it may be in her old chart because she's been in and out but it should be on her active chart. The DON stated it was the policy of the facility the Advance Directive Acknowledgement form should be in the resident's active chart. c. A review of Resident 50's Admission Record (Facesheet) indicated she was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 50's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/16/19, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact and an Advance Directive was not completed. A record review of the physician's orders [REDACTED]. During an interview and concurrent record review of the POLST, on 3/5/20, at 3:16 p.m., with the social services director (SSD) she stated Resident 30's Polestars from 2012 and was the facility's old form. She stated she did not know when the facility changed to the new form. During an interview and concurrent record review of the POLST, dated 7/3/12, on 3/05/20, at 3:24 p.m. with the director of nursing (DON) she stated she thinks Resident 30 was capable of making medical decisions if medical decisions are not complex. She stated at every IDT meeting the plan of care was reviewed and review of the POLST was included. The most recent interdisciplinary team (IDT) meeting was on 12/18/19 and indicated the responsible party was called but no response. She stated the POLST was reviewed at every quarterly IDT meeting the POLST is reviewed. A concurrent record review of Resident 30's History and Physical (H&P) indicated Resident 30 was not capable of making medical decisions. An Advance Directive Acknowledgement Form was not found in Resident 30's active clinical record. A record review of Resident 30's Facesheet indicated Resident 30 had a responsible party and public guardian (regional center). The DON stated the Acknowledgement Directive form should stay on the chart and it was used to document education was provided to resident/family or responsible party. d. A review of Resident 91's Admission Record (Facesheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 91's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/10/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact and an Advance Directive was not completed. A record review of the POLST, signed by responsible party (RP), dated 7/17/18, indicated Resident 91 did not have an Advance Directive and no Advance Directive Acknowledgement Form was found in the clinical record. During an interview and concurrent record review, on 3/6/20, at 7:43 a.m., with the DON she stated the Advance Directive Acknowledgement Form found in Resident 91's clinical record was blank and was not complete. She stated the form was completed by social services and it should be complete and in the resident's active clinical record. e. A review of Resident 129's Admission Record (Facesheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. enough healthy red blood cells) and [MEDICAL CONDITION] (a condition in which the [MEDICAL CONDITION] doesn't produce enough [MEDICAL CONDITION] hormone). A review of Resident 129's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 8/2/19, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact and she did not have an Advance Directive. f. A review of Resident 138's Admission Record (Facesheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 50's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/10/20, indicated she was cognitively (a mental action of acquiring knowledge and understanding) intact and an Advance Directive was not completed. During a record review, the Advance Directive Acknowledgement Form was not found in Resident 138's clinical record. During an interview and concurrent record review, on 3/09/20, at 11:58 a.m., with the SSD, no POLST was found in Resident 138's clinical record and no Advance Directive Acknowledgement Form was found in the clinical record. She stated Resident 149 did not have any family and the H&P, dated 2/28/20, indicated Resident 138 was not able to make medical decisions. During an interview and concurrent record review, on 3/09/20, at 12:03 p.m., with the DON she stated Resident 138 did not have a family or a public guardian. The DON stated the facility's policy if the resident was unable to make medical decisions is the resident is full code. She stated as far as we know there were no family members but we were still exploring. During an interview, on 3/9/20, at 12:26 p.m., with the DON she stated the legal guardianship process for Resident 138 has not been started. The DON stated Social Services was responsible for doing the legwork for this process per the facility's policy. She stated after 30 days, if the resident's surrogate-decision maker could not be located, social service would initiate the legal guardian process. The DON stated the legal guardian process had not been started because the resident was in and out of the facility. During an interview, on 3/9/20, at 12:51 p.m., with the SSD she stated the process for legal guardianship had not been started for Resident 138. g. A review of Resident 149's Admission Record (Facesheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 149's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/27/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact and an Advance Directive was not completed. A record review of the POLST, dated 1/16/20, signed by the responsible party, indicated Resident 149 did not have Advance Directive. During an interview and concurrent record review, on 3/5/20, at 2:26 p.m., with social services designee (SSD1) she stated she had been in this facility and worked for Social Services for about [AGE] years. She stated the Advance Directive Acknowledgement was to be completed when the resident is admitted . She stated the Advance Directive is completed with the resident if the resident is awake and alert and if not; it is completed by calling the Power of Attorney (POA) or family. She stated this is very important for us to have in place and in force. The SSD stated she is not sure why the Advance Acknowledgement Form was not completed for Resident 149. She stated the Advance Directive Acknowledgement is the form used by the facility to indicate if education regarding Advance Directive has been provided to the and/or family. She stated it is the responsibility of Social Services to follow up to ensure the form was completed. A record review of the facility's policy and procedure (P&P), revised 4/2013, titled, Advance Directives, indicated prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical care or surgical treatment, and the right to formulate advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. A review of the facility's policy (P&P), revised 6/2019, indicated the facility shall make efforts to locate the resident's surrogate decision-maker within the first thirty (30) days. The IDT (Inter-disciplinary team) members will act as the resident's surrogate decision-maker until the resident's relative(s) are located with the understanding that no relative(s) may be located, or it may take an extended period of time, while Social Services/Designee is attempting to seek legal public guardianship (if possible).
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure and protect the residents personal and medical information for 10 out of 10 residents (Residents 3, 7, 24, 93, 123, 125, 126, 154, 595, 597) whose discontinued medications were observed exposed in a locked shed outside the facility, and ensure one of one resident's (Resident 94) personal care was not posted on areas visible to other residents and/or visitors. This deficient practice increased the

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F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) risk for unauthorized access and exposure of the residents' sensitive health information and the resident's rights to privacy will be violated. Findings: During an interview on [DATE], at 4:34 p.m., with the DON, stated medications disposed of and awaiting pickup by the facility's contracted medical waste transporter were stored in a biohazard area outside the facility in a shed. The DON stated that she would have to get maintenance to open the shed because she did not have an access to the shed. During an interview on [DATE], at 5:04 p.m., in the presence of the DON, the dietary services supervisor (DSS) stated that she was both the DSS and the facility's environmental director (MHS). DSS stated, I have a key to the biohazard shed and the janitor (the facility's maintenance staff) that brings them (discontinued medications) out from the dirty utility room and the person (facility's outside contracted medical waste transporter) who picks up the medications has access to the outside shed. The medical waste transporter staff have their own key to the shed. No one from the facility is with him when he picks up the medications. The person I see comes very early in the morning and is just one person. I do not see him seal the medications before he takes the medications away. He (medical waste transporter) asks me (DSS) to initial the waste after he has already picked up the medications. Maintenance and I have our own key (to the outside shed). DSS stated the facility has two maintenance employees. During a concurrent observation and interview on [DATE], at 5:04 p.m., in the presence of DSS, the DON stated that she does not have access to the medications in the outside shed. After DSS opened the shed observed inside included a blue unsealed container with medications inside. The DON confirmed residents' information was clearly visible on each of the medications observed inside the blue container. The medications included bottles, vials, antibiotic bags, and boxes of inhalation (breathing treatment) solution in their original containers for residents' (Resident 3, Resident 7, Resident 24, Resident 93, Resident 123, Resident 125, Resident 126, Resident 154, Resident 595, Resident 597). The DON stated the medications should have been removed from their original containers; and identifiable resident information should have been removed prior to disposal of the medications. DON confirmed having unlicensed staff with access to prescription medications in usable, unexpired condition with resident healthcare information on the attached labels. Medications were observed individually labeled for the following residents in the shed located outside of the facility for: 1. Resident 3 medications included, a tube of [MEDICATION NAME] (a topical steroid cream used to reduce swell and itching) 0.1 % (percent) cream in an 8 gram (g) tube with instructions to apply to affected area twice daily for days (therapy ends [DATE]). The label included Resident 3's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 2. Resident 7 medications included, Intravenous (IV, medications injected directly into the vein) bags of Normal Saline (Sodium Chloride, a prescription intravenous medication used to replenish fluids with dehydration and other medical conditions that require additional fluids) labeled for the resident. The label included Resident 7's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 3. Resident 24 medications included, a partial bottle of [MEDICATION NAME] (used to control [MEDICAL CONDITION] (uncontrolled shaking)) 125 mg/4 ml Suspension with instructions to take 8 milliliters (ml) via [DEVICE] (200 mg) every 12 hours for [MEDICAL CONDITION] disorder. The label included Resident 24's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 4. Resident 93 medications included, unopened vials of [MEDICATION NAME] ([MEDICATION NAME]) 4 mg/ 2 ml, with instructions to administer by IVP (intravenous push, a rapid administration of a small volume of medication into a patient's vein) every 4 hours as needed for nausea/vomiting. The label included Resident 93's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 5. Resident 123 medications included, two boxes of [MEDICATION NAME]/ [MEDICATION NAME] (a combination of two medications used to improve breathing) 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer (a device that changes medication from a liquid to a mist so that it can be more easily inhaled into the lungs) every 4 hours as needed for SOB (shortness of breath). The label included Resident 123's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 6. Resident 125 medications included, one box of [MEDICATION NAME]/ [MEDICATION NAME] 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer 8 hours as needed for SOB. The label included Resident 125's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 7. Resident 126 medications included, one box of [MEDICATION NAME]/ [MEDICATION NAME] 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer three times a day for SOB for 5 days (therapy ends [DATE]). The label included Resident 126's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 8. Resident 154 medications included, unopened vials of [MEDICATION NAME] ([MEDICATION NAME], an injectable antibiotic used to treat bacterial infections). The label included Resident 154's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 9. Resident 595 medications included, two boxes of [MEDICATION NAME]/ [MEDICATION NAME] (a combination of two medications used to improve breathing) 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer every 12 hours as needed for [MEDICAL CONDITION] ([MEDICAL CONDITION], a group of lung diseases that block airflow and make it difficult to breathe). The label included Resident 595's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. 10. Resident 597 medications included, premixed IV bags of [MEDICATION NAME] (an injectable antibiotic) - D5W ([MEDICATION NAME] 5 % in Water, the liquid used for preparing injectable medication in an IV bag). The label included Resident 597's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. During an interview on [DATE], at 5:49 p.m., the DON stated, The shed can be accessed while the facility is closed. I will have the medications removed now. During a review of the facility's policy and procedure (P&P) titled, Destruction of Non-Returning Medications, dated ,[DATE], The P&P indicated, Selected discontinued medications and medications left in the facility after a resident's discharge, which did not qualify for return to the pharmacy, shall be destroyed on site. However, the facility failed to develop and implement policy and procedure to guide the facility's licensed staff in protecting resident's health information when disposing of discontinued medications and medications remaining at the facility after residents discharged . During a review of the facility's P&P titled, Discontinued Medications-Disposal, dated ,[DATE], the P&P indicated, Medications shall be sequestered in a secure place within the facility, mutually acceptable to the director of nursing and (the facility's contracted pharmacy services) . (the facility's pharmacy contracted services) shall help facilitate the disposal in a manner consistent with state and federal law . All destructions shall be performed at the facility's location only . (the facility's contracted pharmacy services) shall only help facilitate the destruction to ensure the medications are properly disposed of at the facility. b. During observation in Resident 94's room on [DATE] at 11:32 a.m., Resident 94 was observed lying in bed asleep. Three signs containing care for the resident were posted on the wall above the resident's head. The signs contained written instructions for the resident's care and was visible to anybody who would come in the room or pass by the hallway outside the resident's room. The care signs posted read: 1. Please take out teeth (dentures) every night. Clean and soak with [MEDICATION NAME] tablet every night. Thanks 2. Please keep head of bed elevated at least 20 degrees at all times 3. Please verify bed alarm is connected and working A review of the admission record (face sheet) for Resident 94 indicated resident was admitted to the facility on [DATE], and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the latest minimum data set (MDS-a standardized assessment and care screening tool) dated [DATE], indicated Resident 94 has the ability to make self understood and understand others. The MDS indicated Resident 94 was totally dependent on staff for most of her activities for daily living. A review of a plan of care regarding Resident 94's dental condition, dated [DATE], indicated for staff to assist resident with oral care and denture care daily. During an interview with the Social Services Director 3 (SSD 3) on [DATE] at 3:10 p.m., SSD 3 stated she was the social services assigned to Resident 94's unit but stated she was new, barely a week here, and was not aware of the signs posted on Resident's 94's room. SSD 3 stated that dignity of residents was a joint responsibility of the nurses and social services but social services was responsible for maintaining resident's dignity. A review of the facility's policy and procedure on dignity dated revised on [DATE], indicated staff shall maintain an environment in which confidential clinical information is protected, for example, signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or family member.
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Based on observation, interview, and record review, the facility failed to ensure the residents' toilets were free of black rings, paint on door and wall was not chipped and the caulking at the base of the sink and toilet was not cracked in five of five resident rooms (Rooms 602, 615, 616, 617 and 619). This deficient practice had the potential for the residents comfortable and homelike environment will not be met. Findings: During an observation, on 3/3/20, at 9:57 a.m., resident's bathroom observed with two circular areas of missing flooring (brown in color) on the left and right side of toilet and rust spots on a metal shelf mounted on wall. During an observation in room [ROOM NUMBER], the resident bathroom observed with black marks, chipped paint on door, and left side of the wall and wall facing the door and on the doorframe. During an observation, on 3/3/20, at 10:57 a.m., there were several areas of cracked caulking at the base of the toilet in the bathroom in room [ROOM NUMBER]. During an observation of the resident bathroom in room [ROOM NUMBER], on 3/3/20, at 11:00 a.m., a black ring was observed in the toilet and cracked caulking was observed at the back of the resident's sink. During an observation of room [ROOM NUMBER] bathroom, on 3/3/20, at 12:23 p.m., a black ring was observed in the toilet, cracked caulking was observed at the back of the resident's sink, and chipped paint was observed on the left wall. During an observation and concurrent interview, on 3/6/20, at 12:45 p.m., in room [ROOM NUMBER] bathroom, with maintenance (MA), a black ring in the toilet, chipped paint and cracked caulking was observed in resident bathrooms 602, 615, 616, 617, and 619. During an observation and concurrent interview, on 3/6/20, at 12:57 p.m., with MA he stated he has worked at the facility for [AGE] years. He stated maintenance is done on the resident rooms twice a year and as needed. He stated he keeps a maintenance log on each station. He stated it is important to maintain the residents' bathroom to create a homelike condition for the resident and it makes it easier on everyone when everything is working. A record review of the Maintenance Log, dated 1/2/20 through 3/1/20 did not indicate repair for the black toilet ring, chipped paint, rust or cracked caulking in these rooms. A record review of the facility's policy and procedure (P&P), revised 4/2014), titled, Quality of Life- Homelike Environment, indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extend possible.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure assessments to one out of five sampled residents were accurate and reflective of the resident's status (Residents 162). This deficient practice had the potential for the resident's care and services will not be accurately identified that could affect the resident's health status and well being. Findings: A review of Resident 162's Admission Record (Face Sheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 162's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/4/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required total assistance with a mobility and activities of daily living (ADLs) and he had one unstageable deep tissue injury (DTI). During an interview with minimum data set nurse director (MDS Director) and record review, with the minimum data set nurse (MDS Director) she stated Resident 162 had one Stage 4 (the most serious pressure ulcer) coccyx (tailbone) pressure ulcer (injury to skin and underlying tissues from prolonged pressure on the skin) and one left heel DTI present on admission. A concurrent record review of the MDS, dated [DATE], indicated Resident 162 had one DTI and one Stage 4 pressure ulcer. During an interview, on 3/10/20, 3:38 p.m., with the MDS Director stated she clarified with the wound consult physician that Resident 162's left heel wound classification was clarified from admitted with DTI to a diabetic ulcer on 12/16/19. The MDS Director stated she already admitted that it was an MDS miscoding during an interview. She stated there was a miscoding on the quarterly MDS, dated [DATE]. She stated on the quarterly MDS, dated [DATE], left heel wound was coded as facility acquired and on discharge MDS; dated 6/3/19, the left heel wound was coded as upon admission. The MDS Director stated what we can do it is already done; we can just do the right thing now. A record review of the facility's policy and procedure (P&P), dated, titled, Resident Assessment Instrument, indicated information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop or implement an individualized person-centered care plans for three of 35 residents (Residents 134, 87 and 85). Findings: a. A review of a face sheet indicted Resident 134 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS, a resident assessment and care-screening tool) dated 1/24/20, indicated Resident 134 was totally dependent (full staff performance) with one-person support with bed mobility (moves to and from lying position and turns) eating, and toilet use. A record review of Resident 134 Vital Signs and Weight Record, indicated the resident weighed 140 lbs. when initially admitted . A review of a physician's repopulated order, dated 3/1/20, indicated for Resident 134 to have nothing through the mouth (NPO), and [DEVICE] feeding for diabetic source at 70 milliliters am hour (ml/hr) for 20 hours via enteral pump ([DEVICE]) to start at 12:00 PM until 10:00 am to provide 1680 calories, 1400 milliliters per day (ml/day). A record review of Resident 134's Vital Signs and Weight Record, indicated the resident weighed 136 pounds (lbs.) on 8/6/19 and weighed 129 lbs. on 9/4/19; a weight loss of 7 lbs. in one month. Resident 134 currently weights 122 lbs. A review of Resident 134's care plan titled Actual weight loss of 7 pounds in one month, potential for further weight loss, dated 9/4/19, indicated to offer substitute if intake less than 75% and notify the physician if intake for three meals is less than 75% in 24 hours; offer food preferences and to assist resident with feeding each meal as needed. On 3/5/20 at 2:52 PM, during an interview and record review, Registered Nurse 4 (RN 4) stated Resident 134's care-plan was not individualized; the interventions were not specific to the resident's health status. The resident was on NPO status and the interventions listed on the care plan was directed towards a resident who eats. A review of the facility's policy, titled Care Plans - Comprehensive, revised on 11/2010, indicated as individualized comprehensive care plan that includes measuring objective and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. b. A review of face sheet indicated Resident 87 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS, a resident assessment and care-screening tool) dated 1/15/20, indicated Resident 87 was totally dependent (full staff performance) with one-person support with bed mobility (moves to and from lying position and turns) eating and toilet use. A review of a physician's orders [REDACTED]. A review of Resident 87's care plan titled At risk for decreased in Range of Motion (ROM) on bilateral lower extremities, updated on 2/27/20, indicted for gentle PROM exercise as tolerated for bilateral upper and lower extremities, application of bilateral PRAFO, bilateral grip hands for 4-6 hours or as tolerated. However, the care plan did not indicated the how many times a week the resident was to receive these RNA services. On 3/9/20 at 10:31 am, during an interview and record review, Registered Nurse 2 (RN 2) stated the care-plan did not specify how many times a week Resident 87 was to receive RNA services. RN 2 further stated the care-plan should be completed in order for RNA's and other departments would be aware how often the resident would receive the treatments. A review of the facility's policy, titled Care Plans - Comprehensive, revised on 11/2010, indicated as individualized comprehensive care plan that includes measuring objective and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each c. A review of Resident 85's Facesheet indicated the resident was initially admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED].), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue). A review of Resident 85's Minimum Data Set (MDS - a care and assessment screening tool dated 12/23/19, indicated the resident had no cognitive impairment. The MDS indicated Resident 85 was totally dependent with bed mobility, transfers, and all activities of daily living. A review of Resident 85's weight log indicated the following: On 10/2/19 164 pounds (lb) On 11/5/19 147 lb On 12/2/19 147 lb On 1/5/20 146 lb On 2/4/20 145 lb On 3/4/20 148 lb On 3/09/20 at 12:20 p.m., during a review of the Nutrition Notes with the Registered Dietitian 1 (RD 1), the Tube Feeding (TF) order on admission was [MEDICATION NAME] at 45 milliliter (ml) for 20 hours. The TF order was changed to [MEDICATION NAME] 60 ml for 16 hours or 1760 kilocalories (Kcal) instead of 20 hours to account for the time Resident 85 would be off TF during outpatient [MEDICAL TREATMENT]. A review of Resident 85's care plan indicated that the care plan was updated on 11/20/19, the care plan did not indicate the tube feeding formula and the tube feeding rate per physician's orders [REDACTED]. [REDACTED]., nursing, mental and psychological needs is developed for each resident.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INLAND VALLEY CARE AND REHABILITATION CENTER	250 W. ARTESIA STREET POMONA, CA 91768

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4)
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's interdisciplinary team failed to revise the care plan as appropriate to provide the greatest benefit for one out of 35 residents (Resident 162). This deficient practice has the potential for the resident's highest practicable physical, mental, and psychosocial well-being will not be met. Findings: a. A review of Resident 162's Admission Record (Face Sheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 162's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/4/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required total assistance with a mobility, activities of daily living (ADLs) and toileting use, and supervision with eating. A record review of the Physician order [REDACTED].= 2 units. During an interview and concurrent record review, on 3/9/20, at 3:58 p.m., with licensed vocational nurse (LVN 11), she stated the policy is to rotate sites when administering insulin to residents. LVN 11 stated the injection site should be rotated for each injection. LVN 11 stated the resident points out where he wants the insulin injected and does not want sites rotated. LVN 11 stated we ask him if he wants the injection in his arm and he does not want it because he feels the pain. A review of the Diabetes Mellitus Care Plan did not indicate Resident 162's request to administer insulin injections in area requested and not rotate sites. A review of the facility's policy and procedure, revised 9/2010, titled, Care Plans- Comprehensive, indicated each resident's comprehensive care plan is designed to: a. incorporate identified problem areas. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.
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 35 sampled residents (Resident 7) with long finger nails was provided nail care. This deficient practice placed the resident at risk of skin breakdown and fungal infection. Findings: A review of Resident 7's Face Sheet (Admission Record), indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 7's Minimum Data Set (MDS- a care and screening tool), dated 11/21/19, indicated Resident 7 has no speech, was rarely or never understood and rarely or never understands. Resident 7's cognitive skills for daily decision making is severely impaired. Resident 7 is total dependent on staff with one person physical assist for bed mobility, dressing, and personal hygiene. On 3/4/20 at 11 a.m., during an observation, Resident 7 was in bed receiving morning care provided by Certified Nursing Assistant 3 (CNA 3). The residents finger nails were observed long and broken. During a concurrent interview, CNA 3 said the resident was transferred from another room at the facility to this room. CNA 3 said the resident's hands are contracted (under the palm of the hand becomes thickened and shortened frozen hands. On 3/04/20 at 11:08 a.m., during an observation and concurrent interview with the Director of Nursing (DON), the DON said the resident had long and broken nails, the DON said that placed the resident at risk of skin tear, infection, moisture underneath the nails and potential risk for fungal infection. On 3/4/20 at 11:20 a.m., during a review of Resident 7's medical record and concurrent interview, the DON verified that the resident's long fingernails were not addressed in the plan of care. A review of the Facility's Policy and Procedure, Care of Fingernails/Toenails, revised October 2010, indicated the purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. General guidelines, nail care includes daily cleaning and regular trimming, proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** Based on observation, interview, and record review, the facility failed to provide activities based on resident's interest or preference to one of one resident (Resident 85) out of 35 sampled residents. This deficient practice has the potential to affect the resident's sense of well being, self esteem and emotional health. Findings: On 3/4/20 at 3:40 p.m., during a concurrent observation and interview, Resident 85 stated she liked to watch TV and she liked Mexican music. The television was off at this time. On 3/10/20 at 8:15 a.m., during an interview, Resident 85 stated she would like to listen to Music, resident stated she would get bored with watching TV. A review of Resident 85's Quarterly Activities Assessment, dated 2/7/20, indicated the activities most important to Resident 85 were music, TV, reading to her and sensory stimulation activities. A review of Resident 85's Room Visits/Independent Participation Record and a concurrent interview, indicated the room visits from 3/1/20 to 3/10/20, indicated activities provided were reading the current events, TV, conversations, religious activity and touch for sensory stimulation. The A.D. stated the room visits did not indicate that listening to music was provided and offered to the resident. On 3/10/20 at 8:24 a.m., during an interview, the Activities Director (A.D.) stated when a resident's activity preference indicated that the resident liked music, the Activity Assistants would do room visits and play the radio if the resident had their own radio. The A.D. stated the facility could supply the radio if the resident did not have their own radio. On 3/10/20 at 8:47 a.m., during an observation and a concurrent interview, Resident 85 did not have a music player at the bedside and there was no radio at the bedside. The A.D. stated we will provide a radio to the resident so she can listen to music. A review of the facility's Policy and Procedure titled Activity Evaluation dated May 2013, indicated that the activity evaluation is used to develop an individual activities care plan that will allow the resident to participate in activities of his/her choice and interest.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions that are consistent with resident needs as ordered by the physician to prevent development of pressure ulcers or its recurrence for three of 35 residents (Residents 58, 7, and 37). a. For Resident 58 indicated the following: 1- The Low Air Loss mattress (LAL- a pressure-relieving mattress used to prevent and treat skin breakdown/pressure ulcers (PU- bedsores) settings was not set according to resident's weight. 2- The resident's heels were not off the bed according to Resident 58's care plan. 3- The treatment orders for Pressure ulcers (PUs) were not updated after 21 days according to the physician's orders [REDACTED]. b. For Resident 7, the facility staff failed to ensure the wound did not get contaminated with fecal matter during wound treatment. c. Resident 37's low air loss (LAL, mattress designed to prevent and treat pressure wounds) mattress was not set according to the resident's weight as indicated the resident's care plan. These deficient practices have the potential to cause alteration of skin integrity that could result in delayed wound healing, recurrence and/or development of new pressure sore. Findings: a. A review of Resident 58's Face Sheet (Admission record) indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE]. A review of the Minimum Data Set (MDS) a resident assessment and care screening tool, dated 12/18/19, indicated Resident 58 was not able to understand and made himself understood. Resident 58's cognitive skills were severely impaired (a mental action of acquiring knowledge and understanding). Resident 58 was total dependent with one staff physical assist for bed mobility, dressing and eating. The MDS indicated that Resident 58 was at risk of developing bed sores. The MDS indicated that the resident had a feeding tube (abdominal feeding tube- a flexible tube surgically placed into the abdomen to provide nutrition). The MDS indicated that the resident had one or more unhealed pressure ulcers. On 3/09/20 at 9:05 a.m., during an observation with Licensed Vocational Nurse 1 (LVN 1), Resident 58 was on his back, resident had a pillow under the buttocks. The Low Air Loss (LAL) mattress setting was at 150 to 200 pound (lb) setting. Resident 58 was non-verbal and unable to verbalize needs. During concurrent interview, LVN 1 stated the purpose of the LAL mattress would be to ensure the pressure was off the PU area. The LVN stated Resident 58 had a PU to the sacrococcyx (tailbone) area and placing a pillow underneath the buttocks would make the PU worse and would not help with healing. A review of the Physician Orders, dated 1/27/20, indicated low air loss mattress for wound management. Monitor pressure settings according to patient's weight and comfort, every shift. 1. On 3/09/20 at 2:05 p.m., during an interview, the Director of Nursing (DON) stated the LAL mattress would be set according to resident's weight unless the resident would request to change the setting according to comfort. A review of Resident 58's weights were 150 pounds on 1/26/20 and 138

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) pounds on 2/19/20. A review of Resident 58's Care Plan, Alteration in skin integrity, indicated the resident had Stage 3 pressure ulcer on the right and left heel. The goal is that the pressure ulcer will demonstrate progressive healing. The interventions included to keep heel protectors and elevate foot with pillows in bed. 2. On 3/09/20 at 9:05 a.m., during an observation with LVN 1, Resident 58 was on his back. Resident 58's heels were on heel protectors, the heels were directly resting/touching the bed. During a concurrent interview, LVN 1 stated Resident 58's heels should be elevated and should not be resting directly on the bed to prevent pressure. A review of Resident 58's 3. On 3/5/20 at 3:33 p.m., during a review of Resident 58's Physician order [REDACTED]. -Treatment order dated 1/27/20 for right heel pressure ulcer (PU), to cleanse with normal saline, pat dry, apply Xeroform and cover with foam dressing daily for 21 days. -Treatment order dated 1/27/20 for left heel PU, to cleanse with normal saline, pat dry, apply Xeroform and cover with foam dressing daily for 21 days. -Treatment order dated 1/27/20 for sacrococcyx PU, to cleanse with normal saline, pat dry, apply Venelex ointment, apply zinc oxide to periwound and cover with dry dressing daily for 21 days. -Treatment order dated 1/27/20 for scrotum wound, to cleanse with normal saline, pat dry, apply calcium alginate, & cover with dry dressing daily for 21 days. -Treatment order dated 1/27/20 for right elbow PU, to cleanse with normal saline, pat dry, apply [MEDICATION NAME], & apply dressing daily for 21 days. -Treatment order dated 1/27/20 for perineal redness, to cleanse with normal saline, pat dry, & apply dermaseptin ointment daily for 21 days. 4. A review of the Nutritional Progress Notes dated 2/27/20, indicated a recommendation by the Registered Dietitian to run Diabetisource AC at 50 milliliter per hour (ml/hr) for 20 hours in addition to Prostat 30 ml three times a day to provide 1500 kilocalories (kcal), 105 grams protein. A review of the Recapped Physician order [REDACTED]. A review of the Recapped Physician order [REDACTED]. On 3/10/20 at 11:06 a.m., during an interview, the Minimum Data Set (MDS) Nurse stated that having the right recommendations by the dietitian would help improve wound healing. A review of Resident 58's pressure ulcer care plans indicated the following: -The resident has a stage 3 (full thickness tissue loss, subcutaneous (under the skin) fat may be visible but bone, tendon or muscle are not exposed) PU on the right heel, with interventions to use pressure reducing device/mattress while in bed or wheelchair, apply heel protectors and or elevate foot with pillows in bed. -The resident has a stage 3 PU on the left heel, with interventions to use pressure reducing device/mattress while in bed or wheelchair, apply heel protectors and or elevate foot with pillows. -The resident has a stage 4 PU on the sacrococcyx, with interventions to use pressure reducing device/mattress while in bed or in wheelchair. A review of Resident 58's care plan for risk for slow wound healing indicated for dietary to assess nutritional needs to maintain skin integrity. On 3/10/20 at 10:14 a.m., during a review of Resident 58's medical record and concurrent interview with the facility's consultant Registered Dietician 2 (RD2), RD2 stated the resident's monthly skin review for the date 2/27/20, indicated the resident was receiving Diabetisource AC at 50 milliliter per hour (ml/hr) for 20 hours. According to RD 2, she did not recommend to increase the intake because she felt it was enough feeding intake for the resident, RD 2 said she felt it was enough to meet the resident's needs. According to RD 2, she did not look at the resident when she did the monthly skin review, I did not go in the room to look at the resident or to look at his wounds or his [DEVICE] rate. RD 2 said she did the skin review based on the resident's chart and did not look at the resident. I looked at the wrong order, it was my mistake. The Nutritional Progress Note I did on 2/27/20 was a mistake. A review of Resident 58's LAL mattress (Med Aire plus Alternating Pressure and Low Air Los Mattress Replacement System by Drive) indicated the weight setting buttons can be used to adjust the pressure of the inflated cells based on the patients weights. A review of the Facility's Policy and Procedures, titled, Pressure /Skin Breakdown- Clinical Protocol, revised March 2014, indicated that the Physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings, and application of topical agents if indicated for type of skin alteration. A review of the Facility's Policy and Procedures, , Pressure Ulcer Risk Assessment, revised September 2013, indicated that pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues. The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. Because a resident at risk can develop a pressure ulcer within two to six hours of the onset of pressure, the at risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. b. A review of Resident 7's Face Sheet (Admission Record), indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 7's Minimum Data Set (MDS- a care and screening tool), dated 11/21/19, indicated Resident 7 has no speech, was rarely or never understood and rarely or never understands. Resident 7's cognitive skills for daily decision making is severely impaired. Resident 7 is total dependent on staff with one person physical assist for bed mobility, dressing, and personal hygiene. A review of Resident 7's Physician order [REDACTED]. (highly absorbent dressings that aids in wound healing) then cover with foam dressing, every day for 21 days. On 3/6/20 at 10:11 a.m., during Resident 7's wound treatment observation with Licensed Vocational Nurse/Treatment Nurse 9 (LVN 9). Resident 7 observed with watery bowel movement incontinence. LVN 9 observed cleaning the resident prior to initiating wound treatment and constantly trying to keep the wound site clean. LVN 9 cleansed the resident's bowel movement around the wound site and cleanse the wound with the same soiled dressing. LVN 9 obtained a new dressing moist with normal saline and cleaned the wound again with the new dressing. On 3/6/20 at 10:15 a.m., during an interview, LVN 9 said that if the wound gets contaminated with stool, it could get infected and that stool could excoriate the skin around the wound. According to LVN 9, the wound should not get contaminated with stool per nursing standards of practice. A review of the Facility's Policy and Procedures titled, Pressure Ulcer Treatment, revised September 2013, indicated if using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward). c. Resident 37's low air loss (LAL, mattress designed to prevent and treat pressure wounds) mattress was not set according to the resident's weight as indicated the resident's careplan. A review of face sheet indicted Resident 37 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 37's Minimum Data Set (MDS, a resident assessment and care-screening tool),dated 12/11/19, indicated the resident was totally dependent with one-person assist with bed mobility (moves from lying position), dressing, eating, toilet use and personal hygiene. A record review of a Wound Assessment Report, dated 2/28/20, indicted Resident 37 had a Stage 4 (skin and tissue loss with exposed muscle, tendon, ligament, or bone in the ulcer. Slough and/or eschar may be visible) sacrococcyx (a bone formed by fusion of the sacrum and coccyx) wound measuring 6 centimeters (cm) in length x 6.5 cm in width x 2.6 cm in depth. A record review of a Wound Assessment Report, dated 3/4/20, indicated Resident 37's sacrococcyx wound measured 6.5 cm x 5 cm x 2.6 cm. A review of Resident 37's care plan, titled Alternative in Skin Integrity; Resident has Pressure Ulcer: Stage 4 saccrococcyx, dated 5/2020, indicated for pressure reducing device/mattress while in bed or in wheelchair as part of the facility's actions. A review of Resident 37's care plan titled Resident at risk for: slow wound healing, high risk for development of new sores, worsening of exiting sores with contributing factors of the resident being dependent for transfers and unable to change position independently, dated 2/2020, indicated for LAL mattress for wound management set according to patients weight. A record review title Vital Signs and Weights, indicated Resident 37 weighed 130 pounds (lbs) on 2/4/2020. On 3/3/20 at 9:50 am, during an observation, Resident 37 was observed laying on a Drive LAL set at 200, connected to a ventilator (machine designed to provide mechanical ventilation by moving breathable air into and out of the lungs). On 3/9/20 at 8:45 am, during an interview and record review, Minimum Data Set Nurse Director (MDS) stated Resident 37 was 130 lbs; the LAL mattress should be set at 130, not at 200 set either through weight or comfort. On 3/10/20 at 3:38 PM, during an interview, the Director of Nursing (DON) stated LAL mattress are set up to the residents weight; if the resident weighed 130 lbs., the LAL mattress should be set at 130. A review of Resident 137's LAL mattress (Med Aire plus Alternating Pressure and Low Air Los Mattress Replacement System by Drive) indicated the weight setting buttons can be used to adjust the pressure of the inflated cells based on the patients weights. A review of the facility's care plan titled Support Surface Guidelines, revised on 9/2013, indicated to the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. To review the resident's care plan to assess for any special needs of the resident. Support surfaces are modifiable. Individual resident needs differ.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure two of two (Residents 163 and 151) residents out of 35 sampled residents were adequately supervised and are free of accident hazards. a. For Resident 163, there was no adequate supervision to prevent or minimize risk for accidents. Resident 163 had an unwitnessed fall, and was found on the ground outside by the facility's front door. b. For Resident 151, the facility failed to ensure resident's bed was at the lowest position while the resident was in bed, unattended, according to the resident's plan of care. These deficient practice could result to an increased risk for accidents for the residents, and unwitnessed falls. Findings: A review of the admission record for Resident 163 indicated resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the minimum data set (MDS, a standardized assessment and care screening tool) dated 11/7/19, indicated Resident 163 had the ability to make self understood and understand others. According to the MDS, Resident 163 missed to report the correct year by more than five years, missed to report the correct month by more than one month, and missed to report the correct day of the week. The MDS indicated Resident 163 was totally dependent on facility staff for transfer to and from bed, dressing, toilet use, personal hygiene and bathing, required extensive assistance for bed mobility and locomotion on and off the unit, and supervision with eating. The MDS also indicated Resident 163 did not have any fall since the latest admission. A review of an elopement risk assessment dated [DATE], indicated resident was at risk for elopement. According to this assessment, the intervention being implemented was redirection. A review of a care plan regarding Resident 163's risk for injuries secondary to elopement, dated 11/1/19, indicated resident tends to wander around the facility. Among the interventions listed to ensure resident's safety was to monitor resident's location and do frequent visual check on the resident. A review of a Situation, Background, Assessment, Recommendation (SBAR) communication report dated 2/24/20 indicated a physician called 911 and reported to the charge nurse that Resident 163 was found on the ground outside in front of the facility. The SBAR indicated Resident 163 had a cut with minimal bleeding on the right side of the head and abrasion on the right elbow. A review of the nurses notes dated 2/24/20, indicated that on 2/24/20 at 11:45 a.m., a physician called 911 and reported to the front desk and charge nurse that Resident 163 was found on the ground, lying close to her wheelchair, outside in front of the facility. The nurses notes further indicated Resident 163 sustained an open cut injury with minimal bleeding on the right side of the head and abrasion on the right elbow. During an interview with the director of nursing (DON) on 3/09/20 at 12:52 p.m., she stated that Resident 163 was found on the ground by the front door outside of the facility. DON stated nobody witness the actual fall. DON stated that Resident 163 can wheel her self on the wheelchair. She stated that the Elopement risk for Resident 163 on 9/14/19 indicated resident was at risk for elopement. She stated that it was the facility's responsibility to know the whereabouts of residents and that there should have been somebody with her when she went out of the facility. A review of the facility's policy and procedure regarding wandering and elopement, dated June 2018, under prevention and planning, indicated to account for each resident on a regular basis. b. A review of Resident 151's Face Sheet (Admission Record), indicated the resident was admitted to the facility on [DATE] chronic [MEDICAL CONDITION] (inadequate gas exchange by the respiratory system) requiring ventilator (life support machine). A review of Resident 151's Minimum Data Set (MDS- a care and screening tool), dated 2/3/20, indicated Resident 151 has no speech, was rarely or never understood and rarely or never understands. Resident 151's cognitive skills for daily decision making was severely impaired. Resident 151 was total dependent on staff with one person physical assist for bed mobility, dressing, and personal hygiene. A review of Resident 151's Fall Risk assessment dated [DATE], indicated a score of 16. According to the Fall Risk assessment criteria, if the total score is 10 or greater, the resident should be considered at high risk for potential falls and a prevention protocol should be initiated immediately and documented on the care plan. A review of Resident 151's Fall Risk care plan, dated 1/28/20, indicated the resident was at risk falls related to [MEDICAL CONDITION] disorder (a sudden, uncontrolled electrical disturbance in the brain), the goal was to reduce the risk for falls for 90 days. The interventions included to maintain a safe environment, room free of clutter and keep the bed to the lowest position. On 3/4/20 at 9:43 a.m., during an observation of Resident 151, the resident observed awake in bed, there were floor mats on both sides and the resident's bed was to a high position. On 3/4/20 at 10:33 a.m., during an observation of Resident 151 and concurrent interview with Licensed Vocational Nurse 10 (LVN 10), the resident was in bed with the bed to a high position. LVN 10 said that the resident was at risk for falls upon admission but now the resident did not require to have fall precaution measures because the resident was not able to get out of bed. According to LVN 10 the bed was not to the lowest position. LVN 10 said that the risk of getting injured was less when the bed was to the lowest position and the floor mats are in placed but said that the bed was not to the lowest position. We have to follow the plan of care of keeping the bed to the lowest position until the care plan was reviewed and the measures were discontinued. A review of Resident 151's Physician order [REDACTED]. A review of the Facility's Policy and Procedures titled, Falls and Fall Risk Managing, revised December 2007, indicated that the staff with the input from the attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary care and services for three of 35 sampled residents (Residents 43, 58 and 149): a. Failed to inform the physician regarding Resident 43's urine was cloudy with presence of sediments (cells, debris and other solid matter in urine). b. Resident 58's urinary indwelling Foley catheter (a tube that removes urine from the bladder to a collection bag) was observed with the presence of sediments. c. Resident 149's Foley catheter tubing (a tube that removes urine from the bladder to a collection bag) was observed with white, cloudy urine with sediments (cells, debris, and other solid matter in urine). This deficient practice had the potential to result in catheter related complications such as the worsening of an existing urinary tract infections (UTI, an infection in any part of the kidneys, bladder, or urethra). Findings: a. A review of the admission record for Resident 43 indicated resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. end of the spinal cord and disrupt motor and sensory function to the lower extremities and bladder). A review of the minimum data set (a standardized assessment and care screening tool) dated 12/17/19, indicated Resident 43 has the ability to make self understood and understand others. The MDS indicated Resident 43 is totally dependant on staff for transfer to or from bed and toilet use. Resident 43 required extensive assistance from staff for dressing and personal hygiene, and limited assistance for bed mobility. During an observation and concurrent interview with Resident 43 on 3/03/20 at 9:39 a.m., Resident 43 had a nephrostomy tube (a thin tube placed directly into the kidney through the skin to drain urine) attached to a urine bag. Resident 43's urine was observed to be yellowish in color, and cloudy with sediments. Resident 43 stated he takes care of his own catheter and stated he thinks he has infection in his urine and needs to have a urine exam. Stated he does not know when the last time he had a urine exam. A review of a care plan for Resident 43's nephrostomy tube, dated 11/13/29, indicated resident has a nephrostomy tube because of [MEDICAL CONDITION] (is when urine can't flow either partially or completely through the ureters, bladder, or urethra due to some type of obstruction. The care plan indicated to notify physician promptly for signs and symptoms of UTI. During another interview with Resident 43 on 3/05/20 at 1:15 p.m., Resident 43 stated he did not have any urine exam for infection lately. Resident 43 stated that he did not tell his nurse about how his urine was but the Certified Nursing Assistants (CNA) empties his urine bag everyday and should have seen how his urine was. A review of Resident 43's clinical record indicated there was no documentation that Resident 43 had a urine cloudy with sediments and documented evidence that the physician was notified. During an interview with the Director of Nursing (DON) 3/09/20 at 1:14 p.m., DON stated that Resident 43 is monitored for clogging or dislodged nephrostomy tube to report to the nephrologist. DON stated that Resident 43 is also monitored for infection on the nephrostomy site and the urine is monitored for hematuria (blood in the urine), signs and symptoms of UTI (hematuria, fever, strong odor, sediments/cloudiness), and Nurses should take vitals and notify physician. A review of the facility's policy and procedure regarding Urinary Catheter Care, dated revised on September 2014, indicated residents are observed for signs and symptoms of urinary tract infection and to report findings to the physician or supervisor immediately. b. A

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	056431	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INLAND VALLEY CARE AND REHABILITATION CENTER	250 W. ARTESIA STREET POMONA, CA 91768

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) review of a face sheet indicated Resident 58 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 58, dated 1/28/20, indicated the resident did not have the capacity to understand and make decisions. A review of Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 12/18/19, indicated Resident 58 was totally dependent (full staff support) with one-person assist physical assist with bed mobility (moves to and from lying position), toilet use and personal hygiene. A review of Resident 58's physician's orders [REDACTED]. On 3/9/20 at 9:05 am, during an observation and interview with Licensed Vocational Nurse 1 (LVN 1), Resident 58 was observed lying in bed; his Foley catheter tubing was observed with sediments. LVN 1 stated sediments in the Foley can harm the resident. During a record review of Resident 58's care plan titled Incontinence Bowel and Bladder, the document was left blank; the document had the resident name, however, it did not indicate the residents problems/needs, goals or approaches/plans. A review of the facility's policy titled Catheter Care - Urinary, revised on 9/2014, indicated for the purpose of the procedure was to prevent catheter-associated urinary tract infections, to observe the resident for complications associated with urinary catheters. To check the urine for unusual appearance (color, blood, etc). c. A review of Resident 149's Admission Record (Facesheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 149's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/27/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he had a catheter and he was required total assistance with toilet use. During an observation, on 3/4/20, 2:24 p.m., white, cloudy sediment was observed in Resident 149's catheter tubing. During an interview, on 3/4/20, at 2:45 p.m., with certified nurse assistant (CNAs 1), he stated CNAs check and empty residents' catheter bag. He stated the catheter bag was emptied at the end of the shift and when it was full. CNAs 1 stated CNAs checked the catheter tubing and bag for blood and sediment and that the bag was not touching the floor. During an observation and concurrent interview, on 3/4/20, at 2:53 p.m., with licensed vocational nurse (LVN 2) she stated she checked the catheter bag earlier today. LVN 2 stated the CNAs should report cloudiness in the urine. LVN 2 stated there was sediment in Resident 149's catheter tubing. She stated sediment could be an infection. LVN 2 stated we have to monitor it and it should be flushed. During an interview, on 3/4/20, at 3:13 p.m., CNAs 2 she stated she was assigned to Resident 149 today. She last checked the catheter tubing and bag at about 10:30 a.m. A concurrent observation at the bedside with the LVN 2 and CNAs 2, the Resident 149's catheter bag was observed full and with sediment in the tubing. During an interview, on 3/5/20, at 11:45 a.m., with the director of nursing (DON) she stated the Foley catheter care was done every shift and the facility's policy to change urine bag and tubing every Sunday. She stated the tubing and bag was assessed for sediments and hematuria as well as the color of the urine. The DON stated sediments were white appearance and sediments that would indicate the resident might need more fluid or had an infection. She stated hematuria was a sign of bleeding or infection. She stated it was the licensed nurse's responsibility to assess the urine and tubing and the CNAs can observe the color. The DON stated the CNAs would report the color, sediments, or no urine output to the charge nurse and stated the urine bag is emptied every shift. The DON stated the licensed nurse would check urine quality, tubing and amount as part of her assessment. A record review of the facility's policy and procedure (P&P), revised 9/2014, titled, Catheter Care, Urinary, indicated observe the resident for complications associated with urinary catheters. Check the urine for unusual appearance (i.e. color, blood, etc.). A record review of the facility's policy and procedure (P&P), revised 9/2014, titled, Catheter Care, Urinary, indicated observe the resident for complications associated with urinary catheters. Check the urine for unusual appearance (i.e. color, blood, etc.).
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide nutrition to prevent weight loss for one of two sampled residents (Resident 58) by failing to: 1. Ensure Resident 58 received gastrostomy tube feedings ([DEVICE], a tube inserted through the belly that brings nutrition directly to the stomach) as recommended by the Registered Dietitian (RD, food and nutrition expert) to increase the [DEVICE] feeding to meet the recommended daily nutritional intake and prevent significant weight loss (a loss of 4.5 kilogram (kg)/9.9 pounds (lbs) or > 5 percent (%) of the usual body weight in one month). 2. Monitor and record Resident 58's weight weekly, for four weeks, as ordered by the physician and recommended by the RD. These deficient practices resulted in Resident 58 losing 12 lbs/8% of the usual body weight within five weeks (1/26/20 to 3/4/20) and placed the resident at risk for delayed in pressure sores (bedsores) healing. Findings A review of Resident 58's Admission Record indicated the facility admitted the resident on 12/12/19 and readmitted the resident on 1/26/2020 with [DIAGNOSES REDACTED]. A review of Resident 58's Minimum Data Set (MDS, standardized assessment and care-planning tool), dated 12/18/19, indicated the resident has severely impaired cognitive skills (ability to think and process information). The MDS indicated Resident 58 was totally dependent with one-person physical-assist for bed mobility, transfers, eating, dressing and personal hygiene. The MDS indicated Resident 58 had a [DEVICE] for medication and nutrition. A review of Resident 58's Malnutrition Risk Assessment, dated 1/26/2020 indicated the resident had a score of 13 (a score of 10 or greater considered a high risk for malnutrition (lack of sufficient nutrients in the body)). A review of Resident 58's Physician Orders, dated 1/26/20, indicated for staff to administer Diabetisource AC (formula designed for residents with diabetes), 50 cubic centimeter (cc) per hour (hr) for 20 hrs, to provide a total of 1000 cc/1200 calories (Kcal, amount/unit of food energy) to infuse from 2 PM to 10 am. Prostat (protein supplement), 30 cc via [DEVICE], three times per day for wound management. A review of Resident 58's Admission Weight Log, dated 1/27/2020, indicated the resident's admission weight was 150 lbs. A review of Resident 58's History and Physical (H&P), dated 1/28/2020, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 58's Vital Sign (signs of life including heart beats and temperature) and Weight Record Log, dated 1/29/2020 to 3/4/2020, indicated the resident's weights were as follows: 1. 1/29/20 = 150 lbs. 2. 2/5/20 = 146 lbs (four lbs of weight loss in 5 days). 3. 2/12/20 = 140 lbs (six lbs of weight loss in seven days/10 lbs of weight loss in 12 days). 4. 2/19/20 = No weight recorded. 5. 2/26/20 = No weight recorded. 6. 3/4/20 = 138 lbs (12 lbs of weight loss in one month and six days). A review of Resident 58's Care Plan for Feeding Tube, dated 1/31/20, indicated the resident had the potential for malnutrition secondary to receiving [DEVICE] feeding. The goal was for the resident to be free from malnutrition daily for the next 90 days. The approached interventions were for staff to administer [DEVICE] feeding as ordered and refer to the RD for adequacy of current feeding formula and flow rate. A review of Resident 58's Care Plan for Weight Loss, dated 1/31/20, indicated the resident was at risk for weight loss. The goal was for Resident 58 to be free from significant weight loss of 5 lbs per month for the next 90 days. The care plan was updated on 2/12/2020 with an intervention for staff to increase the [DEVICE] feeding. A review of Resident 58's Nutrition Screening and Assessment, dated 1/31/2020, indicated the resident's current/desired body weight was 68.2 kg/150 lbs. Resident 58's calorie needs were 1705 - 2046 Kcal per day. The assessment indicated RD 1 recommended to increase the Diabeticsource AC feeding from 50 to 60 cc/hr for 20 hours to provide 1200 cc/1440 Kcal, plus Prostat to equal to 1740 Kcal, 117-gram (gm) protein (the assessment did not indicate the type nor how many cc of Prostat). A review of Resident 58's Physician Order, from 1/31/2020 to 2/12/2020, indicated there was no order to increase the [DEVICE] feed as indicated in the Nutrition Screening and Assessment. A review of Resident 58's Nurses Note, from 1/31/2020 to 2/12/2020, indicated there was no explanation to why the physician was not notified regarding the RD 1's recommendation to increase the [DEVICE] feeding from 50 to 60 cc/hr. A review of Resident 58's Medication Administration Record [REDACTED]. A review of Resident 58's Interdisciplinary (IDT, team meeting among healthcare professionals to discuss the resident's plan of care) Weight Variance Review Report, dated 2/12/2020, completed by RD 2, indicated Resident 58 lost 10 lbs. The report indicated RD 2 recommend increasing the [DEVICE] feeding with Diabeticsource AC to 65 cc/hr, for 20 hours, to equal 1,300 cc/1560 Kcal with Prostat supplement to equal to 1860 Kcal per day due to the current tube feeding was inadequate. RD 2 recommended for staff to continue to weigh Resident 58 once a week for four weeks. A review of Resident 58's Physician Orders, dated 2/13/2020, indicated for staff to administer Diabetisource AC 65 cubic centimeter (cc) per hour (hr) for 20 hours to provide a total of 1200 cc/1440 Kcal to infuse from 2 PM to 10 am. A review of Resident 58's Physician Orders, dated 2/13/2020, indicated for staff to weigh the resident once a week for four weeks. A review of Resident 58's MAR, from 2/14/2020 to 3/5/2020, indicated the resident received [DEVICE] feed with Diabetisource AC, at 65 cc/hr for 20 hours from 2 PM to 10 am. A review of Resident 58's MAR, from 2/21/2020 to 3/8/2020, indicated the resident received [DEVICE] feed with Diabetisource AC, at 60 cc/hr for 20 hours from 2 PM to 10 am. (from 2/21/2020 to 3/8/2020, nursing staff documented they administered [DEVICE] feeding on both MARs). A review of Resident 58's Physician Orders, dated 2/21/20, indicated for staff to administer Diabeticsource AC, at 60 cc/hr for 20 hours, to provide a total of 1,200 cc/1440 Kcal and to infuse from 2 PM, to 10 am, or until dose is met. During an observation on 3/4/2020, at 10 am, Resident 58 was receiving Diabeticsource

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F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 8) AC at 60 cc/hr via [DEVICE] feeding. A review of Resident 58's Physician Orders, dated 3/5/2020, indicated to discontinue the resident [DEVICE] feeding of Diabeticsource AC at 65 cc/hr for 20 hours. During a concurrent interview and review of Resident 58's IDT Weight Variance report on 3/6/2020, at 3:55 PM, RD 1 stated she and RD 2 assess Resident 58 once a month and as needed to evaluate for significant weight changes. RD 1 stated when Resident 58 had a significant weight change, RD 1 and RD 2 wrote their recommendations in the resident's Nutritional Progress Notes and the IDT Weight Variance Review and handed their recommendations to the Facility's Dietary Supervisor (DS). RD 1 stated the DS's job is to deliver the RDs' recommendations to the charge nurses or the Registered Nurse Supervisors. RD 1 stated they (RD 1 and RD 2) did not attend the IDT meeting to discuss Resident 58's significant weight loss. During a concurrent observation and interview with RD 1, on 3/6/20 at 4:32 PM, Resident 58 was receiving Diabeticsource AC at 60 cc/hr via [DEVICE] feeding. RD 1 stated the setting on the [DEVICE] feeding was wrong and Resident 58's [DEVICE] feeding should be set at 65 ml/hr according to the RD's recommendations. During an interview on 3/6/2020 at 4:33 PM, Registered Nurse Supervisor 4 (RN 4) stated she placed a request for a RD consultant for Resident 58 due to the resident had a significant weight loss. During an interview and concurrent review of Resident 58's Nutrition Screening and Assessment and the IDT Weight Variance Review Report, on 3/9/2020 at 9:34 am, RD 2 stated it is important to increase Resident 58's Diabeticsource AC via [DEVICE] to 65 cc/hr due to the resident suffered from significant weight loss and unhealed bedsores. RD 2 stated it is important for Resident 58's weight to be stable to prevent further wounds (bedsores) deterioration. RD 2 stated losing weight would compromise Resident 58's skin integrity and delayed wound healing due to the resident did not receive enough calories. During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 03/9/2020 9:49 am, Resident 58 was receiving Diabeticsource AC at 60 cc/hr. LVN 1 turned the [DEVICE] feeding pump (a machine that deliver the formula via [DEVICE]) off. LVN 1 stated Resident 58 received a total of 1200 cc/1440 Kcal in 20 hours (not 1560 Kcal as recommended by the RD 2). During an interview on 3/10/2020, at 7:29 am, Restorative Nurse Assistant 1 (RNA 1) stated he did not weigh Resident 58 weekly due to the charge nurse did not inform him to weigh the resident weekly. During an interview on 3/10/2020, at 3 PM, the Director of Nurses (DON) stated that it was important for nursing staff to monitor Resident 58's weight weekly as ordered by the physician. The DON stated the RDs and the license nurses are responsible for notifying the physician of the RD recommendations and monitor Resident 58's weight on a weekly basis. The DON stated there was no specific licensed nurse assigned to monitor Resident 58's weights but all licensed nurses were responsible to monitor the weights. The DON stated the facility does not have a policy and procedure for staff to follow regarding weekly weight. A review of the facility's Policy and Procedures titled, Nutritional Assessment, revised in September 2011, indicated the Dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and change in condition that places the resident at risk for impaired nutrition. The policy indicated the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting date and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. The policy indicated the nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the usual body weight and recent events that may have affected a resident's nutritional status and risk factors.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to respond to the resident's ventilator (life support machine) alarm to ensure one of three sampled residents (Resident 446) reviewed for [MEDICAL CONDITION] (a surgical opening performed through the front of the neck into the windpipe or trachea, a tube is placed into the opining to keep it open for breathing), received suctioning to prevent choking due to excessive secretions. This deficient practice had the potential to cause in difficulty of breathing and distress to the resident due to increased secretions. Findings: A review of Resident 446's admission records indicated resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 446's Care Plan for Respiratory Cared, dated 3/5/20, indicated the resident had impaired gas exchanged (a severe clinical condition defined as an excess or deficit in blood oxygenation and/or carbon [MEDICATION NAME] elimination) related to ineffective airway clearance. The goal included to maintain a patent airway and improve ventilation (flow of oxygen and carbon [MEDICATION NAME] in and out of the lungs). The interventions included to assess for any changes in respiratory status as needed and during patient care rounds and to maintain airway clearance every two hours and as needed. On 3/6/20 at 7:16 a.m., while performing rounds at nurses station 2, observed two facility staff members walking on the hallways. On 3/6/20 at 7:16 a.m., while doing morning rounds in nurses station unit two, heard an alarm, while walking on the hallway outside room [ROOM NUMBER]. Observed two facility staff members on the hallway near room [ROOM NUMBER] talking to each other, the survey team walked pass the two staff members and enter room [ROOM NUMBER]. Upon entering the room, observed Resident 446 with copious amount of secretions coming down from her mouth and observed foaming on her mouth and trache, the resident appeared agitated and the ventilator alarm kept ongoing, indicating High Pressure. The two staff members staff outside the room did not come in the room to respond to the alarm until the surveyor called for help. Licensed Vocational Nurse 7 (LVN 7) walked in the room and immediately right after performing hand hygiene and donning gloves, started suctioning the resident. On 3/6/20 at 7:20 a.m., during an interview with the Respiratory Therapist 1 (RT 1) stated that she was on the other side of the unit and came to the room when a staff member called her to come to room [ROOM NUMBER]. According to RT 1, the licensed nursing staff was able to suction the residents that need suctioning. RT 1 said that if there was an emergency the staff would call her, an emergency included if the resident was not breathing or was having respiratory distress. According to RT1, she covers 14 to 15 residents during her shift. ON 3/6/20 at 7:26 a.m., . during an interview, LVN 8 said he was the charge nurse for the residents in Nurses Station 2, including Resident 446. According to LVN 8, he was doing the morning rounds and was performing suction to another resident when he heard the alarm in room [ROOM NUMBER] go off. LVN 8 said he came to the room as soon as he was done suctioning the other resident. LVN 8 said that alarms are very important because it indicates any issues with the ventilators or if the residents are able to breathe or need to be suctioned. According to LVN 8, they want to prevent the residents from having any difficulty breathing by suctioning every two hours of as needed. According to LVN 8, high pressure on the Ventilator would indicate that the resident is coughing and causing higher pressure in their chest, if there is foaming of the mouth and saliva secretions coming out the mouth and trache means that the resident needs suctioning and that the airway is not clear and the resident is not able to breathe. On 3/6/20 at 10 a.m., during an interview with the Director of Nursing (DON) stated that according to the facility's policy on ventilators, the healthcare providers should respond to the ventilator alarms right away. It is important to responds to ventilator alarms because the alarms can indicate if there is trache dislodgement (unplanned decanulation/removal of the [MEDICAL CONDITION]), the ventilator can be disconnected, the resident may require suctioning. If the resident requires suctioning, the airway is not patent (the state of being open or unobstructed). If the resident requires suctioning, the airway is not patent, it can be life threatening to the resident if the resident is not able to breath. According to DON, if she was in the unit and heard a vent alarm go off, she would expect her staff to respond to the alarm immediately. A review of the Facility's Policy and Procedures, Policy number R-0161, undated, indicated that it is the responsibility of all health care providers to respond immediately to all ventilator alarms. Personnel will perform corrective action within their scope of practice to resolve the problem. Failure to respond immediately to ventilator alarms can be life threatening to the patient.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on record review and interview, the facility failed to ensure two of two certified nurses aids (CNAs) employee files reviewed received performance review at least once every 12 months. This has the potential for the staff to lack knowledge to provide appropriate care services and special care needs to the residents. Findings: On 3/9/20 at 3:30 p.m., during a review of employee files, Certified Nursing Aid 5 (CNAs 5) and Certified Nursing Aid 6 (CNAs 6) did not receive a performance for over 12 months. On 3/9/20 at 3:50 p.m., during a review of employee files and concurrent interview with the Director of Staff Development (DSD) stated that CNAs 5 was hired on 7/24/18. The next performance evaluation was due to be performed on 7/24/19, however it was not done. DSD said that CNAs 6 was hired on 9/27/17 and that the annual performance evaluation was due on 9/25/19 but still it was not done. According to DSD, she was new to the facility and still trying to catch up.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Post nurse staffing information every day.** Based on interview and record review, the facility failed to post the facility name, total number of projected and actual

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	056431	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INLAND VALLEY CARE AND REHABILITATION CENTER	250 W. ARTESIA STREET POMONA, CA 91768

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 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) hours worked by licensed and unlicensed staff directly responsible for resident care per shift and the resident census for the sub-acute (comprehensive inpatient care designed for someone who has an acute (severe) illness) unit. Findings: a. On 3/9/20 at 4:30 PM, during an observation with the Vice President of Operations (VPO), the facility's nursing staff for the sub-acute unit was observed hanging on the wall next to the nurse's station. The document was titled SNF - Projected Daily NHPPD (Census and Direct Service Hours Per Patient Day) did not indicate the units facility name, total number of projected and actual hours worked by licensed and unlicensed staff and the resident census. During a concurrent interview, the VPO stated the sub-acute unit posting was separate from the SNF units in the facility. VPO also stated the posting on the sub-acute unit of the facility indicated the staffing information for the SNF units of the facility and not the sub-acute unit. VPO also stated it was important to make sure residents are provided accurate care for the residents for transparency, and to properly inform the public. On 3/9/20 at 4:44 PM, during an interview, the administrator (ADM) stated staffing should be posted daily; it should have the accurate information such as staff ratios, who is taking care of whom and in what units. ADM further stated it was important to provide residents and their families who is taking care of the residents.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure secure access is maintained by only the director of nursing (DON) to have access to controlled substances (medications with a high potential for abuse) awaiting destruction for three of 35 residents (Resident 29, 128, 149) whose controlled medications were observed inside an Intravenous (IV, medications delivered by injection into the vein) Medication Cart (MedCart) on Station 1. This deficient practice increased the facility's risk for the potential loss, diversion (transfer of a medication from a legal to an illegal use) or accidental exposure to controlled substances. Findings: On 3/4/2020 at 1.51 p.m., during an observation on Station 1, of the IV MedCart, a Registered Nurse (RN 3) opened the IV MedCart and observed inside were unused controlled medication cards (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication) wrapped with the individual residents' Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) with an attached undated note that indicated: NOC Shift Pls give to DON for: 1. Resident 29 the controlled medication cards contained, 30 tablets of [MEDICATION NAME] (a medication use to treat anxiety (a mental health disorder characterized by excessive worry or fear.)) 0.5 milligrams (mg) with a fill date of 11/17/2019 and 14 tablets of [MEDICATION NAME] (a medication used to treat sleeping problems) 5 mg with a fill date of 11/17/2019. 2. Resident 128 the controlled medication card contained one tablet of [MEDICATION NAME] 1 mg with a fill date of 3/2/2020. 3. Resident 149 the controlled medication card contained 30 tablets of the combined medication [MEDICATION NAME] (an opioid (narcotic) pain reliever) and [MEDICATION NAME] (a non-Opioid pain reliever) 7.5 mg/ 300 mg with a fill date of 12/20/2019. During a concurrent interview on 3/4/2020, at 1:51 p.m., RN 3 stated the controlled medications observed in the hallway of Station 1, inside the IV MedCart were from Station 6 and the note on the medications indicated the night shift nurse was to give the medication to the DON. During a concurrent interview and record review, on 3/4/2020, at 2:41 p.m., RN 3 stated, There is no date or reason written to indicate why the medications were pulled. I cannot tell because there is nothing written on the bubble packs. RN 3 stated she would have to review each of the residents (Resident 29, 128, and 149) records to identify why the controlled medications were left inside the IV MedCart. After reviewing the medication records RN 3 stated for: 1. Resident 29, There are no current orders for these medication ([MEDICATION NAME] and [MEDICATION NAME]) in the computer system . [MEDICATION NAME] was discontinued 12/12/2019 and [MEDICATION NAME] was discontinued 12/12/2019. 2. Resident 128, [MEDICATION NAME] was filled on 3/2/2020 and the Nursing Notes dated 3/3/2020, at 2:44 p.m., documented that the resident declined the medication. 3. Resident 149, [MEDICATION NAME]/[MEDICATION NAME] 7.5/ 300 mg was discontinued 2/219/2020. RN 3 confirmed there was no discontinued date recorded on the medication cards (bubble pack) or Controlled Drug Record. RN 3 stated, When the controlled medications are discontinued we have to give them to the DON. Why the medications are in the IV MedCart is my question. The controlled medications should not be in the MedCart once the medication was discontinued. During an interview on 3/4/2020, at 5:49 p.m., the DON stated, Nurses (facility's licensed nurses) should give the discontinued controlled medications to me right away. During a review of the facility's policy and procedure (P&P) titled, Pharmaceutical Services Policy and Procedure Manual, dated 4/2019, The P&P indicated, The director of nursing and the consultant pharmacist shall maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications .Controlled medications remaining in the facility after the order has been discontinued shall be retained in the facility in a securely locked area with restricted access until destroyed . by the facility's director of nursing in conjunction with the consultant pharmacist . Controlled medication storage, records and expiration dates shall be routinely monitored by the consultant pharmacist during medication storage inspection.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act upon the pharmacist's recommendations regarding drug irregularities for two of 35 residents (Residents 168 and 62). a. For Resident 168, there was no documented evidence the rational for the continued use of Departed (used to treat manic episodes associated with [MEDICAL CONDITION] disorder) was in the medical record. b. Resident 162, the facility staff failed to identify a drug irregularity for the administration of [MEDICATION NAME] 10 milligrams (mg). This deficient practice had the potential for the residents receiving unnecessary medication administration. Findings: a. A review of a face sheet indicated Resident 168 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 168's History and Physical, dated 5//3/19, indicated the resident did not have the capacity to understand and make decisions. A review of a physician's orders [REDACTED]. A record review of a Medication Administration Record [REDACTED]. A record review titled Note to Attending Physician/Prescriber, (NAPP) dated 2/17/20, completed by the facility's pharmacist consultant indicated, Resident 168 takes Departed 500 mg at house sleep since 6/19 to manage inappropriate behaviors or stabilize mood Please review the resident behaviors and consider a gradual dose reduction at this time. The document also indicated if therapy is continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated in the area provided below or progress notes. The NAPP further indicated the physician agreed with the above recommendation, please implement as per consultant pharmacist. On 3/4/20 at 2:41 PM, during an interview and record review, the Assistant Director of Nursing (ADON) stated the pharmacist recommendations were not followed. The orders was not clarified if Departed was to be reduced or not. [MEDICAL CONDITION] medications, taken unnecessarily can ruin your liver; the least medications the better. A review of the facility's policy titled Antipsychotic Medication Use, updated on 3/2015, indicated all antipsychotic medications will be used within the dosage guidelines . or clinical justification will be documented for dosages that exceeds the listed guidelines for more than 48 hours. b. A review of Resident 162's Admission Record (Face Sheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 162's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/4/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required total assistance with a mobility and activities of daily living (ADL's) and he was given antipsychotic medication. During an interview and concurrent record review of the Physician Orders, on 3/10/20, at 10:54 a.m., with the assistant director of nursing (ADON) she stated Resident 162 was given [MEDICATION NAME] 10 mg, by mouth (PO), every day (QD), started on 7/29/18. The ADON was not able to provide documentation of a gradual dose reduction (GDR) attempt for [MEDICATION NAME] 10 mg. She stated the physician was unable to attempt a GDR because Resident 162 goes in and out of the facility. A record review of the Physician Orders, dated 5/4/18, indicated Resident 162 was given [MEDICATION NAME] 5 mg, via [MEDICAL CONDITION] tube (G tube) mouth, in the morning, started on 5/4/18. On 7/29/18, Resident 162 was given [MEDICATION NAME] 10 mg, PO, QD and no documentation of a GDR attempt was found in the clinical record. During an interview, on 3/10/20, at

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) 11:19 a.m., with the ADON she was not able to provide documentation of a Medication Regimen Review from the pharmacist for [MEDICATION NAME] 10 mg, PO, QD. During an interview, on 3/10/20, at 4:06 p.m., with the consultant pharmacist (CP) he stated Resident 162 was readmitted on ,[DATE], 9/2018, 12/2018, 3/2019, 6/2019, 12/2019 and 1/2020. The CP stated the reason why a GDR was not attempted for Resident 162 was due to the resident was frequently in and out of the facility. CP stated each readmission was taken as a new start and he watched behaviors for a couple of months after a remittance and then reassessed. CP stated he based his GDR frequency on behaviors and the medication itself. The CP stated antidepressants take four to five months to work and antipsychotics take a few weeks but what he found psychiatrists were hesitant to adjust medications for residents right out of the hospital. CP stated he thinks the 1st quarter after resident was readmitted would be reasonable time frame to make a recommendation based on resident's behavior. A record review of the policy and procedure (P&P), dated 1/2019, titled, Monthly Drug Regimen Review, indicated resident-specific DRR recommendations and findings shall be documented and acted upon by the facility and/or physician.
F 0758 **Level of harm** - Actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for one out of 35 sampled residents (Resident 162). This deficient practice had the potential to put the resident at risk for receiving unnecessary medication. Findings: A review of Resident 162's Admission Record (Face Sheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 162's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/4/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required total assistance with a mobility and activities of daily living (ADL's) and he was given antipsychotic medication. During an interview and concurrent record review of the Physician Orders, on 3/10/20, at 10:54 a.m., with the assistant director of nursing (ADON) she stated Resident 162 was given [MEDICATION NAME] 10 mg, by mouth (PO), every day (QD), started on 7/29/18. The ADON was not able to provide documentation of a gradual dose reduction (GDR) attempt for [MEDICATION NAME] 10 mg. She stated the physician was unable to attempt a GDR because Resident 162 goes in and out of the facility. A record review of the physician's orders [REDACTED]. A record review of the Physician Orders, dated 3/2020, indicated Resident 162 was given [MEDICATION NAME] 10 mg, PO, QD and documentation of a GDR attempt was not found in the clinical record. A record review of the facility's policy and procedure (P&P), revised 3/2015, titled, [MEDICAL CONDITION] Medication Use, indicated [MEDICAL CONDITION] medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reductions. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rate of five percent (5%) or greater, as evidenced by the identification of two medication errors out of 28 opportunities (observations during medication administration) for error, to yield a cumulative error rate of 7.14% for two out of six residents observed during the medication administration facility task (Residents 87 and 69): 1. For Resident 87, facility failed to administer [MEDICATION NAME] ([MEDICATION NAME] HCL, a medication used to restore normal heart rhythm and maintain a regular, steady heartbeat) as ordered daily. 2. For Resident 69, facility failed to administer [MEDICATION NAME] (used to treat [MEDICAL CONDITION] and/or nerve pain) one tablet within 60 minutes of scheduled time of 8 a.m. These deficient practices had the potential to result in harm to Resident 87 and Resident 69 by not administering medication as prescribed by the physician in order to meet their individual medication needs. Findings: a. A review of Resident 87's Face Sheet indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 87's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 1/15/2020 indicated the resident was unable to communicate wants or needs. The MDS indicated the resident is totally dependent on staff for activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 87's March 2020 Physician order [REDACTED]. order date of 1/25/2020 and a renewal date of the same order on 3/3/2020. On 3/3/2020 at 10:08 a.m., during medication pass observation, Licensed Vocational Nurse 6 (LVN 6) was observed preparing ten medications for Resident 87 with two medications being held [MEDICATION NAME] (blood pressure medication) 50 mg and [MEDICATION NAME] HCL 200 mg. LVN 6 prepared and administered eight out of ten medications. During a concurrent interview LVN 6 stated after checking Resident 87's heart rate that the heart rate was 58 and she would not administer the resident's [MEDICATION NAME] or [MEDICATION NAME] HCL. LVN 6 stated the parameter for both medications were to hold the medications for heart rate of less than 60 heart beats per minute. A review of Resident 87's March 2020 Physician order [REDACTED]. Hold for SBP (Systolic Blood Pressure, pressure when the heart is pumping blood, normal SBP is 120 mm Hg (millimeters of mercury) or less) less than 110 mm Hg or heart rate less than 60 heartbeats per minute for hypertension (high blood pressure). [MEDICATION NAME] HCL 200 mg, give one tablet via [DEVICE] every 12 hours for [DIAGNOSES REDACTED] fibrillation. There was no parameter or physician order [REDACTED]. A review of Resident 87's Medication Administration Record [REDACTED]. On 3/4/2020 at 5:30 p.m., during an interview and a review of resident 87's clinical records the assistant director of nursing (ADON) stated there were no parameter to hold Resident 87's [MEDICATION NAME] HCL. ADON stated [MEDICATION NAME] do not usually have a parameter to hold the medication. ADON confirmed the physician order [REDACTED]. A review of the facility's policies and procedures titled Pharmaceutical Services Policy and Procedure Manual, effective date 04/2019 indicated, Medications shall be administered in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications shall do so only after they have familiarized themselves with the medication . Medications shall be administered in accordance with written orders of the attending physician. b. A review of Resident 69's Face Sheet indicated resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 69's MDS dated [DATE] indicated the resident has intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident required setup and supervision for eating, limited assistance for personal hygiene, extensive assistance for bed mobility and dressing, and was totally dependent on staff for transfer from bed to chair and toilet use. A review of Resident 69's Physician order [REDACTED]. On 3/4/2020 at 9:32 a.m., during medication pass observation, Licensed Vocational Nurse 4 (LVN 4) was observed preparing seven medications for Resident 69. LVN 4 prepared and administered each medication that included [MEDICATION NAME]. On 3/4/2020 at 9:53 a.m., after medication pass, LVN 4 was asked about the [MEDICATION NAME] that was ordered to be administered to Resident 69 a t 8 a.m. LVN 4 stated that she was running late with Resident 69's [MEDICATION NAME] and she would need to discuss with the physician. On 3/4/2020 at 5:29 p.m., during an interview the director of nursing (DON) stated, medications should be administered between one hour before administration time up to one hour after administration time. A review of the facility's policies and procedures titled Pharmaceutical Services Policy and Procedure Manual, effective date 04/2019 indicated, Medications shall be administered within 60 minutes of scheduled time.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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: 1. Ensure a resident's (Resident 596) home medications were disposed of according to facility's policy titled, Medications Brought to Facility by Resident or Family

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F 0761

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 11)
Member, and did not remain in the facility for over 30 days after resident's discharge. 2. Ensure limited access to discontinued prescription medications individually labeled in their original containers which included ten residents (Resident 3, 7, 24, 93, 123, 125, 126, 154, 595, 597). The medications were stored outside the facility in a locked shed with the facility's dietary and maintenance staff, and facility's contracted medical waste transporter having independent key access to the shed and the unsealed, unexpired prescription medications awaiting final disposal. (Cross Reference with F583). 3. Ensure, noncontrolled medication destruction logs included the names of each medication being disposed of and the signatures of the licensed nurse and/or a witness for the disposal. These deficient practices increased the risk of improper medication storage, exposure of residents' sensitive health information, and lack of accountability and control for all medications throughout the facility from receipt to destruction. Findings: 1. During an observation on [DATE], at 4:34 p.m., with the Director of Nursing (DON), inside the DON's office, the bottom drawer of a locked cabinet contained a bag filled with medication bottles and a resident's (Resident 596) identification cards. The bag included bottles of prescription and nonprescription medications individually labeled for Resident 596 that included the following, antihypertensive (medications to treat high blood pressure) medications, [MEDICATION NAME] XL (an antidepressant used to treat major [MEDICAL CONDITION]), [MEDICATION NAME] (a medication used to treat major [MEDICAL CONDITION], anxiety and panic disorder), Aspirin, [MEDICATION NAME] (a muscle relaxer), and [MEDICATION NAME] (a medication used to treat [MEDICAL CONDITION] (uncontrollable shaking), and also used to treat nerve pain). During a concurrent interview and record review on [DATE], at 4:34 p.m., the DON stated Resident 596 was discharged from the facility on [DATE] (102 days ago). DON stated, These were medications that were brought from home and not medications that Resident 596 was using while at the facility. If the family brings in medication with the resident, we would send the medications home with the family or hold the medications for the resident. We can hold on to the medications for six months. A review of Resident 596's Face Sheet (Admission and Discharge Record) indicated the resident was admitted to the facility on [DATE] at 5:30 p.m., and was discharged on [DATE] at 6:30 p.m. Discharge Status documented, Return Not Anticipated. During a review of the facility's policy and procedure (P&P) provided by the DON, titled, Medications Brought to Facility by Resident or Family Member, dated ,[DATE], the P&P indicated, Medications brought into the facility by a resident or family member shall be used only upon written order by the resident's attending physician . Medications not ordered by the resident's physician, or unacceptable for other reasons, shall be returned to the family or designated agent. If unclaimed within thirty days, the medications are disposed of in accordance with facility medication destruction/disposal procedures. 2. During an interview on [DATE], at 4:34 p.m., with the DON, inside of her office, the DON stated medications disposed of and awaiting pickup by the facility's contracted medical waste transporter were stored in a biohazard area outside of the facility in a shed. The DON stated that she would have to get maintenance to open the shed because she did not have a key. During an interview on [DATE], at 5:04 p.m., in the presence of the DON, the dietary services supervisor (DSS) stated that she was both the DSS and the facility's environmental director (MHS). DSS stated, I have a key to the biohazard shed and the janitor (the facility's maintenance staff) that brings them (discontinued medications) out from the dirty utility room and the person (facility's outside contracted medical waste transporter) who picks up the medications has access to the outside shed. The medical waste transporter staff have their own key to the shed. No one from the facility is with him when he picks up the medications. The person I see comes very early in the morning and is just one person. I do not see him seal the medications before he takes the medications away. He (medical waste transporter) asks me (DSS) to initial the waste after he has already picked up the medications. Maintenance and I have our own key (to the outside shed). DSS stated the facility has two maintenance employees. During a concurrent observation and interview on [DATE], at 5:04 p.m., in the presence of DSS, the DON stated that she does not have access to the medications in the outside shed. After DSS opened the shed observed inside included a blue unsealed container with medications inside. The DON confirmed residents' information was clearly visible on each of the medications observed inside the blue container. The medications included bottles, vials, antibiotic bags, and boxes of inhalation solution in their original containers for residents' (Resident 3, Resident 7, Resident 24, Resident 93, Resident 123, Resident 125, Resident 126, Resident 154, Resident 595, Resident 597). The DON stated the medications should have been removed from their original containers; and identifiable resident information should have been removed prior to disposal of the medications. DON confirmed having unlicensed staff with access to prescription medications in usable, unexpired condition with resident healthcare information on the attached labels. Medications were observed individually labeled for the following residents in the shed located outside of the facility for: a. Resident 3 medications included, a tube of [MEDICATION NAME] (a topical steroid cream used to reduce swell and itching) 0.1 % (percent) cream in an 8 gram (g) tube with instructions to apply to affected area twice daily for days (therapy ends [DATE]). The label included Resident 3's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. b. Resident 7 medications included, Intravenous (IV, medications injected directly into the vein) bags of Normal Saline (Sodium Chloride, a prescription intravenous medication used to replenish fluids with dehydration and other medical conditions that require additional fluids) labeled for the resident. The label included Resident 7's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. c. Resident 24 medications included, a partial bottle of [MEDICATION NAME] (used to control [MEDICAL CONDITION] (uncontrolled shaking)) 125 mg/4 ml Suspension with instructions to take 8 milliliters (ml) via [DEVICE] (200 mg) every 12 hours for [MEDICAL CONDITION] disorder. The label included Resident 24's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. d. Resident 93 medications included, unopened vials of [MEDICATION NAME] ([MEDICATION NAME]) 4 mg/ 2 ml, with instructions to administer by IVP (intravenous push, a rapid administration of a small volume of medication into a patient's vein) every 4 hours as needed for nausea/vomiting. The label included Resident 93's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. e. Resident 123 medications included, two boxes of [MEDICATION NAME]/ [MEDICATION NAME] (a combination of two medications used to improve breathing) 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer (a device that changes medication from a liquid to a mist so that it can be more easily inhaled into the lungs) every 4 hours as needed for SOB (shortness of breath). The label included Resident 123's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. f. Resident 125 medications included, one box of [MEDICATION NAME]/ [MEDICATION NAME] 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer 8 hours as needed for SOB. The label included Resident 125's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. g. Resident 126 medications included, one box of [MEDICATION NAME]/ [MEDICATION NAME] 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer three times a day for SOB for 5 days (therapy ends [DATE]). The label included Resident 126's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. h. Resident 154 medications included, unopened vials of [MEDICATION NAME] ([MEDICATION NAME], an injectable antibiotic used to treat bacterial infections). The label included Resident 154's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. i. Resident 595 medications included, two boxes of [MEDICATION NAME]/ [MEDICATION NAME] (a combination of two medications used to improve breathing) 0XXX,[DATE] mg/ 3 ml, with instructions to inhale 1-unit dose via hand held nebulizer every 12 hours as needed for [MEDICAL CONDITION] ([MEDICAL CONDITION], a group of lung diseases that block airflow and make it difficult to breathe). The label included Resident 595's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. j. Resident 597 medications included, premixed IV bags of [MEDICATION NAME] (an injectable antibiotic) - D5W ([MEDICATION NAME] 5 % in Water, the liquid used for preparing injectable medication in an IV bag). The label included Resident 597's name, medication, room number, physician's name, pharmacy name and telephone number, and prescription number. During an interview on [DATE], at 5:49 p.m., the DON stated, The shed can be accessed while the facility is closed. I will have the medications removed now. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated ,[DATE], the P&P indicated, Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance state regulations and federal guidelines regarding disposition of non-hazardous medications . Take the medication out of the original containers . Document the disposal on the medication disposition record. 3. During a concurrent observation and interview on [DATE], at 3:32 p.m., with Registered Nurse (RN) 4, on Nursing Station 2 inside the Medication Room, RN 4 provided the noncontrolled destruction log. After reviewing the log, RN 4 stated, I cannot make out the names of the medications being disposed of because they (facility's licensed nurses) put the stickers too close. The stickers were observed covering up the names of the medications that were disposed on the following dates, [DATE], [DATE], [DATE], [DATE], and [DATE]. RN 4 stated, It is important to know what medication is being disposed of and not just the name of the resident. RN 4 confirmed

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) the facility's form titled, Facility Medication Destruction Form, were missing the names of two licensed nurses or witness as required, checked by, and verified by, both spaces were left unsigned. RN 4 confirmed the medication storage room serviced three out of the six Nursing Stations (Nursing Stations 1, 2, and 3) in the facility. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated ,[DATE], the P&P indicated, Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance state regulations and federal guidelines regarding disposition of non-hazardous medications . Take the medication out of the original containers . Document the disposal on the medication disposition record. Include the signature (s) of at least two witnesses . The medication disposition record will contain the following information: a. The resident's name; b. Date medication disposed; c. The name and strength of the medication; d. The name of the dispensing pharmacy; e. The quantity disposed; f. Method of disposition; g. Reason for disposition; and h. Signature of witnesses. Complete medication disposition records shall be kept on file in the facility for at least two (2) years, or as mandated by state law governing the retention and storage of such records.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure food items for the employees were not stored in the same refrigerator used for the residents. This had the potential risk for cross contamination for food borne illness. Findings: During an observation in the facility's kitchen on 3/03/20 at 9:10 a.m., food items for the employees were observed on the bottom shelve of one of the reach-in refrigerator together with food items for the residents. Some of the food items for the employees were not labeled for the employees, such as half empty bottle of coke, a jar of jalapeos, and small jars of sauce and pickles among others. During an interview with the dietary services supervisor (DSS) on 3/3/20 at 9:15 AM, she stated that she did not know that they are not supposed to store food items for employees in the refrigerator used for the residents. DSS stated they will be taken out right away. A policy and procedure regarding storage of food items for employees were requested, however, the facility does not have a policy regarding this.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 implement and maintain infection control practices and prevention program for five of 35 residents (Residents 345, 346, 162, 64, and 156). This deficient practices had the potential to result in a delay in providing the necessary services to prevent or control infection. Findings: a. A review of Resident 345's Admission Record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 345's Minimum Data Set (MDS - a care and assessment screening tool) dated 3/2/20, indicated the resident had memory impairment and unable to understand and unable to express ideas and wants. The MDS indicated the resident was totally dependent with bed mobility and all activities of daily living. A review of Resident 346's Admission Record indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 346's MDS dated [DATE], indicated the resident was unable to understand and unable to express ideas and wants, the resident had memory impairment. The MDS indicated Resident 346 was totally dependent with bed mobility and all activities of daily living. On 3/3/20, at 12:16 p.m., during an observation and a concurrent interview, Resident 345 was in a room with an isolation precaution sign at the door. Resident 345 was in A bed located near the door and Resident 346 was in B bed located next to the patio door. A review of Resident 345's Recapped Physician order [REDACTED].(GACH) records dated 2/27/20, indicated Resident 345 was on MDRO/contact precautions for Acinetobacter species of the sputum. On 3/06/20 at 9:57 a.m., during an interview, the Infection Prevention Nurse (I.P Nurse) stated Resident 345 was on contact isolation for multidrug resistant organism (MDRO) of the sputum and the roommate, Resident 346 had no infections. During the same interview, the I.P Nurse stated Resident 346 had a [MEDICAL CONDITION] and an indwelling urinary catheter. The I.P Nurse stated she notified admissions there was no appropriate placement for Resident 345 because there was no other resident at the facility with the same infectious bacteria. A review of Resident 346's Recapped Physician order [REDACTED]. The Physician orders [REDACTED]. On 3/9/20 at 8:57 a.m., during an interview, Resident 345 and Resident 346 should not be cohorted because we don't want the clean patient to contract the bacteria that the patient on isolation has. A review of the Facility's Policy and Procedure titled Isolation & Enhanced Standard Precautions dated September 2009, indicated the roommate of the contact precaution resident without history of the same organism should have no invasive procedure sites, should have intact skin and should not be immunocompetent. A review of the Facility's Policy and Procedure (P&P) titled Policy for Management of Acinetobacter Baumannii undated, indicated Acinetobacter Baumanii has been identified as the cause of infections most often seen in critically ill patients receiving invasive medical interventions such as urinary catheters, central lines, arterial lines, and mechanical ventilation. Acinetobacter is capable of surviving for extended periods of time from a few weeks to months on inanimate surfaces thereby creating opportunity for contact transmission. Acinetobacter baumanii infections are even more difficult to manage when the infecting strain exhibits multi-drug resistance. The P&P indicated if a private room is not available, cohort the multidrug resistant Acinetobacter resident with another resident, colonized or infected, with the same organism. If such a roommate is not available, cohort with a resident who has low risk for infection with no invasive procedure sites, intact skin, no infection or on any antibiotics). b. On 3/6/20 at 11:02 a.m., during a concurrent infection control and antibiotic surveillance record review and interview, the I.P Nurse stated residents who were started on antibiotics were logged on a surveillance record. The I.P Nurse stated residents with signs and symptoms of possible infection but not on antibiotics were not included in the surveillance record. On 3/6/20 at 11:42 a.m., the I.P Nurse stated tracking residents with the same signs and symptoms are important to identify and understand the trend of these signs and symptoms and know when isolate residents with the same symptoms in one area of the facility. A review of the facility's Policy and Procedure titled Surveillance Program, dated October 2012, indicated that surveillance is a key component of infection prevention and control, whereby, the I.P collects data on the residents' clinical conditions as it relates to possible infection. In addition to data collection, the I.P must analyze the information gathered and then develop strategies on how to prevent further infection transmission. c. A review of Resident 162's Admission Record (Face Sheet) indicated he was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 162's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/4/20, indicated he was cognitively (a mental action of acquiring knowledge and understanding) intact, he required total assistance with a mobility, activities of daily living (ADL's) and toileting use, and supervision with eating. During an observation, on 3/9/20, at 10:20 a.m., two urinals were observed in Resident 162's bathroom. During a concurrent interview with licensed vocational nurse (LVN 5), she stated Resident 162 has a suprapubic catheter and his catheter is emptied in the urinal. During an observation and concurrent interview, on 3/9/20, at 10:28 a.m., Resident 162's bathroom with certified nurse assistant (CNA 1) he stated he is assigned to room [ROOM NUMBER] Bed A and B. Two urinals were observed in Resident 162's bathroom. CNA 1 stated the urinal observed behind the toilet belonged to the resident in Bed B and the urinal observed hanging from the rail next to the toilet belonged to the resident in Bed A. He stated the urinals should be labeled with the resident's name and the resident's bed to identify the urinals because there could be cross contamination since they are not labeled. d. A review of Resident 64's Admission Record (Face Sheet) indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 64's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/26/19, indicated she was severely cognitively (a mental action of acquiring knowledge and understanding) impaired, she required extensive to total assistance with activities of daily living (ADL's) and supervision with eating. e. A review of Resident 156's Admission Record (Face Sheet) indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 156's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/3/20, indicated she was severely cognitively (a mental action of acquiring knowledge and understanding) impaired, she required total assistance with activities of daily living (ADL's) and eating. During a dining observation in the East Dining Room, on 3/3/20, at 12:41 p.m., a resident was observed moving the table, taking and drinking the red juice drink of another resident seated at the table. A review of Resident 64's tray card indicated the resident was given 4 oz. of apple juice. Resident 64's paper food mat in front of her was observed with red staining. A review of Resident 156's tray card indicated she was given 4 oz. of punch. During an interview, on 3/3/20, at 12:41 p.m., with CNA 3 she stated this was a problem with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INLAND VALLEY CARE AND REHABILITATION CENTER	**250 W. ARTESIA STREET POMONA, CA 91768**

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) infection control because the other resident probably already touched the food. During an observation and concurrent interview, on 3/3/20, at 12:51 p.m., with CNA/restorative nursing aide (RNA) 4 she stated usually when they are on RNA program, there was usually an RNA employee monitoring so residents do not getting into each other's food. She stated there are four RNA's in the dining room now and assigned to this room normally. CNA/RNA 4 stated she was supposed to be at the table with the two residents but they had called her to do something at the station so that was why she was not there. CNA/RNA 4 stated it was infection control and the residents may be on different diets. She stated there were four RNAs and six CNAs assigned to the East Dining Room. Staff was not observed at the two residents' table. A record review of the facility's policy and procedure (P&P), dated 9/30/09, titled, Isolation & Enhanced Standard Precautions, indicated it is the policy of this facility to utilize Standard Precautions as a foundation of standard of care for all residents regardless of diagnosis. Standard Precautions will be practiced by all personnel and will be used for all residents at all times.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a system to monitor appropriate use of antibiotic to improve resident outcomes and reduce antibiotic resistance for two of five residents (Resident 46 and Resident 75). a. Resident 46 was on [MEDICATION NAME] (antibiotics) and there was no Surveillance Data collected regarding it's use for urinary tract infection [MEDICAL CONDITION]. b. Resident 74 was on Cefurosime [MEDICATION NAME] (antibiotics) and [MEDICATION NAME] (antibiotics) and there was no Surveillance Data collected regarding it's use for pneumonia (infection of the lungs). This deficient practice had the potential to result in the development of antibiotic-resistant organisms (not effective to treat infection), from unnecessary use or inappropriate antibiotic use. Findings: a. A review of Resident 46's Physician order [REDACTED].P Nurse) dated December 2019, indicated an order for [REDACTED].P Nurse stated there was no documentation that a Surveillance Data Collection Form was completed for Resident 46's use of [MEDICATION NAME]. The I.P Nurse stated the Surveillance Form had to be completed within 1 to 2 days when the antibiotic was ordered. b. A review of Resident 75's Surveillance Data Collection Form dated 3/3/2020, indicated the form was not completed. A review of Resident 75's Physician order [REDACTED].P Nurse) stated that for the month of March, the Surveillance Data Collection Forms were not yet completed. The I.P Nurse stated the process would be for the charge nurse to fill out the Surveillance Data Collection Form when obtaining orders for antibiotics from the physicians, the I.P Nurse would be the one to determine whether the infection meets the McGeers criteria (this criteria de?ne infections such as urinary tract infections [MEDICAL CONDITION], respiratory infections, for guidance purposes to increase the likelihood of capturing true infections) or did not meet criteria. A review of the facility's Policy and Procedure titled Surveillance Program, dated October 2012, indicated all licensed nurses are responsible for participating in the infection control data collection process. As residents are identified with possible infection events the licensed nurse identifying the change in the resident's clinical condition must start an assessment sheet. The I.P will oversee this process for accuracy and thoroughness of information collected.