STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555785	A. BUILDING _____ B. WING _____	03/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COURTYARD CARE CENTER	1880 DAWSON AVENUE SIGNAL HILL, CA 90806

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 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 ensure a comprehensive resident-centered plan of care was developed, and implemented for one of 12 residents (16). Residents 16, who was receiving weekly blood drawn both at the facility and at the [MEDICAL TREATMENT] (a process of purifying the blood of a person whose kidneys are not working normally) center for low hemoglobin (a red protein responsible for transporting oxygen in the blood), and hematocrit levels (low blood count in the body), was receiving [MEDICATION NAME] (a prescription medicine used to treat a lower than normal number of red blood cells caused by [MEDICAL CONDITION] in patients on [MEDICAL TREATMENT] to reduce or avoid the need for red blood cell [MEDICAL CONDITION]) injections due to low hemoglobin (a red protein responsible for transporting oxygen in the blood) levels at the [MEDICAL TREATMENT] center was not coordinated and care planned, to ensure monitoring, communication to stop [MEDICATION NAME] from exceeding the level set per physician's orders [REDACTED]. Findings: A review of Resident 16's Admission Face sheet indicated the resident was admitted to the facility on [DATE] and re-admitted [DATE], with [DIAGNOSES REDACTED]. A review of Care Plans dated 2/3/20 indicated Resident 16 did not have a interventions specifically for weekly blood monitoring for low hemoglobin and hematocrit count, [MEDICATION NAME] administrations, and the set level at which the [MEDICATION NAME] was to be dosed at. A review of Resident 16's History and Physical report dated 12/18/19 indicated Resident 16 did not have the capacity to understand and make decisions. A review of Resident 16's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 8/27/19 indicated Resident 16 had cognitive impairment for daily decision making. The MDS assessment indicated Resident 16 required staff assistance with bed mobility, transferring to and from bed, chair or a standing position, moving from one location to another, dressing, toilet use, and personal hygiene. A review of Resident 16 blood laboratory work dated 2/18/20 indicated the resident had a low hemoglobin level (normal level of 2.0 to 15.5 grams per deciliter (gm/dl) of 9.9 gm/dl, and the hematocrit (normal levels 37% to 48%) levels were 32.2 %. A review of daily laboratory work monitoring indicated Resident 16 had been receiving weekly blood draws to monitor hemoglobin and hematocrit levels since 12/19/19 - 3/8/20. A review indicated facility did not develop interdisciplinary team meeting or a plan of care regarding Resident 16's weekly blood drawn for hemoglobin and hematocrit blood levels and there was no documented evidence about the [MEDICATION NAME] levels. On 03/08/20 at 3:14 p.m., during interview Registered Nurse (RN 1) stated Resident 16 laboratory weekly blood drawn done at the [MEDICAL TREATMENT] center was supposed to be care planned in order to coordinate the care with the center. RN 1 stated Resident 16 was getting weekly blood drawn because of the [MEDICATION NAME] she was receiving. RN 1 stated Resident 16's blood draws were supposed to be care planned so results of the laboratory could be monitored and reported to the primary physician, dietician between both facilities. RN 1 stated further follow up with [MEDICATION NAME] levels (measures the amount of protein made by the liver), complete blood count (gives information about the cells in a person's blood), and complete metabolic panel (blood test that measures sugar level, electrolyte and fluid balance, kidney function, and liver function), was monitored on a weekly basis. RN 1 stated having a care plan to know the Resident 16's progress, and use it as problem solving to address care was necessary. A review of facility's policy and procedure titled Baseline Care Plans dated 12/2016 indicated to assure the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission. The interdisciplinary team will review the healthcare practitioner's orders (e.g, dietary needs, medications, routine treatments,) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders [REDACTED]. Dietary orders, d. Therapy services, e. Social services, and f. PASARR recommendation, if applicable.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care met professional standards of quality for two of 12 residents (4, 20) by: Resident 4, the staff used sani-wipes (wet wipes used to disinfect surfaces) to clean the resident's [MED] pen (is used to inject [MED] for the treatment of [REDACTED]. Resident 20, the same spoon was used to mix the different medications with water after it was crushed, and the right amount of water was not administered in between each gastrostomy tube ((GT) a tube inserted through the abdomen that delivers nutrition directly to the stomach) medication administrations. Resident 44, who was diabetic (abnormal blood sugar levels), the finger stick (blood sugar monitoring) was done after all the medications were administered, but not prior to checking blood sugar levels, which could result in alteration of [MED] (a hormone that balances blood sugar levels) coverage. These deficient practices resulted in potentially causing skin irritation for Resident 4, not flushing with water inbetween each Resident 20's medications could cause physical interactions of the medications, and elevate Resident 44's blood sugar requiring unnecessary use of [MED] to control the high blood sugar level. Findings: a. A review of Resident 4's Admission Face Sheet indicated the resident was admitted to the facility on [DATE] with an original admitted d 12/27/2019. Resident 4's [DIAGNOSES REDACTED]. A review of Resident 4's history and physical assessment form dated 2/26/2020 indicated the resident had the capacity to understand and make decisions. A review of Resident 4's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated [DATE], indicated the resident was able to understand and be understood by others. The MDS indicated Resident 4 had difficulty communicating some words and thoughts needing prompting or time to complete expressions. The MDS indicated Resident 4 required a one person's assist with bed mobility, transfer, moving from one location to another, dressing. Eating, toilet use and personal hygiene. The MDS also indicated Resident 4 was receiving [MED]. A review of Resident 4's physician order [REDACTED]. A review of Resident 4's Medication Administration Records (MARs) dated 3/7/2020 at 4:30 p.m., indicated the resident was to receive 4 units of [MED] SQ. On 03/07/20 at 04:54 p.m., during a concurrent interview and medication pass observation, Licensed Vocational Nurse (LVN 1) used disinfectant sani-wipes to clean the tip of Resident 4's [MED] [MED] pen needle prior to administering it. LVN 1 stated sani-wipes were used to prevent infection. On 03/07/20, at during a concurrent interview and review of literature on sani-cloth germicidal disposable wipes, the Director of Nursing (DON) stated the facility used alcohol wipes to clean [MED] pens and not use sani-cloth because according to the literature, it was not meant to be used on the skin. The DON stated the cloth should not come in contact with the skin because it could cause skin irritation. A review of the facility's policy titled [MED] Administration, with a revised date of 10/2010 indicated to disinfect the top of the vial with alcohol wipe. b. A review of Resident 20's Admission Face Sheet indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 20's history and physical assessment form indicated the resident could make needs known but could not make medical decisions. A review of Resident 20's care plan dated 1/31/20 indicated the resident required tube feeding related to dysphagia and swallowing problem. The interventions indicated to check for tube placement and

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) gastric contents/residual (refers to the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) volume per facility's protocol, listen to lung sounds, provide total assistance with tube feeding, and water flushes as ordered by the physician. A review of Resident 20's physician orders [REDACTED]. The order indicated to administer [MEDICATION NAME] 5 mg via GT daily for HTN, aspirin 81 mg via GT daily as a blood thinner, [MEDICATION NAME] 20 mg via GT daily, [MEDICATION NAME] 20 mg via GT daily for HTN, [MEDICATION NAME] 850 mg via GT two times daily via GT, and [MEDICATION NAME] 25 mg via GT every 12 hours for HTN. A review of Resident 20's Medication Administration Records (MARs) dated 3/8/20 at 9 a.m., indicated the resident received [MEDICATION NAME] 5 mg, aspirin 81 mg, [MEDICATION NAME] 20 mg, [MEDICATION NAME] 20 mg, [MEDICATION NAME] 850 mg, [MEDICATION NAME] 25 mg, and [MEDICATION NAME]-[MEDICATION NAME]. A review of Resident 20's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 12/20/19 indicated Resident 20 was not able to understand and be understood by others. The MDS indicated Resident 20 required two persons assist moving from a lying position, turning side to side, moving from bed, chair, wheelchair and standing position. The MDS indicated Resident 20 required a one person's assist dressing, eating, toilet use, eating and personal hygiene. The MDS also indicated, Resident 20 was on GT feeding. On 03/08/20 at 09:13 a.m., during a concurrent medication pass observation, and review of Resident 20's MAR, LVN 2 used one spoon to mix [MEDICATION NAME] 25 mg, [MEDICATION NAME] 5 mg, aspirin 81 mg, [MEDICATION NAME] 25/250 mg, [MEDICATION NAME] 20 mg, [MEDICATION NAME] 20 mg, and [MEDICATION NAME] 850 mg, that was crushed and placed them in individual cups before administering them to the resident. LVN 2 did not flush with 15 ml of water inbetween the medications administered. LVN 2 stated medications were crushed and placed in separate cups to show which medications were being administered. On 03/08/20 at 10:35 a.m., during a concurrent interview and review of the facility's policy on preparation and guidelines for administering medication via GT, the director of Nursing (DON) stated to prevent side effects and drug to drug interactions, a separate spoon must be used to mix medications prior to administration. A review of the facility's policy titled Preparation and General Guidelines for Administering Medication via Enteral Tube updated on 10/2019 indicated each medication is administered separately to avoid interaction and clumping. The policy indicated the tube feeding was flushed with at least 10-15 milliliters (unit of measurement) of water between each medication to avoid physical interactions of the medications. c. A review of Resident 44's Admission Face sheet indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 44's Care Plan dated 12/28/19 indicated the resident was diagnosed with [REDACTED]. A review of Resident 44's History and Physical assessment form dated 1/8/20 indicated the resident had the capacity to understand and make decisions. A review of Resident 44's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 11/19/19, indicated the resident had cognitive impairment with daily decision making. Resident 44 required staff's assistance with bed mobility, transferring to and from bed, chair or a standing position, moving from one locomotion to another, and dressing. A review of Resident 44's Medication Administration Records (MARs) dated 3/7/20, indicated the resident received the following medications: [REDACTED]. calcium acetate take with meals On 03/07/20 at 05:01 p.m., during medication pass observation of evening shift med pass with Licensed Vocational Nurse (LVN 7), the following medications were administered to Resident 44: isosob mono 60 mg 1 tab [MEDICAL CONDITION] 6.25 mg 1 tab [MEDICAL CONDITION]-sugar free 30 ml supplement for protein supplement. calcium acetate take with meal On 03/07/20 at 05:01 p.m., during observation LVN 7 performed finger stick to determine Resident 44's blood sugar level after all medication were administered to the resident. LVN 7 stated Resident 44's blood sugar level was 210 mg/dl, and administered [MEDICATION NAME] R [MED], 3 units for coverage. During concurrent interview LVN 7 stated she was supposed to have checked the resident's blood sugar prior to medication administration to obtain accurate reading of the blood sugar. LVN 7 acknowledged there was supposed to be nothing given to Resident 44 by mouth before checking the blood sugar to ensure accuracy. A review of facility's policy and procedure titled Medication Administration, dated 10/2019, indicated prior to administration, the medication and dosage schedule on the resident's Medication Administration Record [REDACTED]. The policy indicated if the label and MAR indicated [REDACTED].
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to use the communicated board per the policy to enhance communication during care to one of 12 residents (33), who was non-verbal. The deficient practice resulted in lack of appropriate communication between staff and Resident 33, during assisted feeding task. Findings: A review of Resident 33's Admission Face sheet indicated the resident was admitted to the facility initially on 8/7/19 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 33's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/2/19 indicated Resident 33 had cognitive impairment (the ability to understand and be understood by others) with daily decision making. A review of Resident 33's Care Plan dated 8/7/19 indicated the resident required assistance with activities of daily living due to medical conditions such as [MEDICAL CONDITIONS], and developmental delays. The care plan indicated the resident required assistance in bed mobility, transfer, locomotion in unit, locomotion off unit, dressing, toileting, hygiene, eating, and bathing. The care plan interventions indicated the staff to assist the resident as needed with showers, toileting and locomotion. A review of Resident 33's care plan dated [DATE] titled Communication deficit indicated the resident was non-verbal due to [DIAGNOSES REDACTED]. The care plan intervention indicated to provide communication board as needed during care. On 03/07/20 at 08:00 a.m., during observation Registered Nurse (RN 2) was assisting Resident 33 with feeding. RN 2 was having difficulty communicating with Resident 33 during care. When asked how she communicated the care to Resident 33, RN 2 stated she used sign language. When asked if the resident had a communication board for staff to use during care, RN 2 stated Resident 33 did not have one. During interview, another staff who was sitting in the room assisting another resident with the meal, stated there was a communication board in a folder on Resident 33's table. However, the communication board was in a folder placed on a bedside table with other items on top of it. The folder was not posted in a visible area where it could be seen and utilized by staff during Resident 33's care. On 03/07/20 at 03:34 p.m., during interview RN 2, stated she was only work in the facility for four months, and stated I am a new RN, I did not know Resident 33 have a communication board. I will make sure the communication board is kept within a visible place so that every staff will know how to use it to communicate residents care with the resident. I do use sign to communicate care with resident. I did not learn sign language, I just use sign for simple things like eat, turn. I did not have any clue about the communication board and the use in providing care to resident. A review of an undated facility's policy and procedure titled Communication Barriers Reduction indicated it is the policy of the facility to provide methods of communication to assure adequate communication between the resident and staff. The policy indicated methods instituted to assist the resident in communicating their needs will be identified in the resident's plan of care. The policy indicated the facility will make arrangements for interpreters or alternate means of communication, such as pictures, sign language, braille, to enhance communication between the resident and staff.
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.** Based on observation, interview and record review, the facility failed to appropriately destroy and discard controlled drugs (are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled which are regulated and classified by Drug Enforcement Administration, based on how likely they are to cause dependence) per the policy. This deficient practice had a potential to cause misappropriation and abuse of controlled drugs. Findings: On 03/07/20 at 04:15 p.m., during a concurrent interview and medication storage and labeling observation, a 17 gallon biohazard container with an unlocked lid, that was half filled with medications, was observed in the medication room. The Director of Nursing (DON) stated the medications in the container were a mixture of unused controlled and non-controlled drugs, in its original form was awaiting to be discarded. The DON stated the biohazard

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) container was usually picked up on Wednesdays by an outside company for destruction. The DON also stated facility's pharmacist, in the presence of the DON removed the medications from their original containers, and threw them in the biohazard container, without ensuring it became non-retrievable, so they could not be reused. The DON stated she was not sure which medications were in the container because non-controlled medications were also placed in that container by the licensed nurses. The DON stated the opening in the container was large enough for anyone to conveniently take out medications from the container and the medications were still in their original form. A review of a Medical Waste Tracking document dated 3/4/2020 indicated a 43-gallon regulated medical waste was picked up. Per the DON, that was the last time medical waste was picked up from the facility. However, the document did not indicate the 17-gallon biohazard container that was half filled with medications was picked up. A review of the facility's policy titled Discarding and Destroying Medications with a revised date of 10/2014 indicated all unused controlled substances would be retained in a securely locked area with restricted access until disposed of. The policy indicated the unused controlled substances would be removed from the original containers, mixed with an undesirable substance like sand, coffee grounds, kitty litter or other absorbent materials. According to this policy, the waste mixture would be placed in a sealable bag, empty can or another container to prevent leakage. This policy stated that destruction of a controlled substance must render it non-retrievable to alter the physical and chemical properties of the medication.
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 infection control protocols that reduced or prevented the spread of infection for one of 12 residents (4) by: Resident 4, staff used a blood pressure cuff on the resident without hand hygiene (the use of alcohol-based hand rubs containing 60%-95% alcohol and hand washing with soap and water), and did not clean the blood pressure cuff before and after its use. Resident 4, staff did not perform hand hygiene before, during and after administering medications to the resident The staff failed to ensure proper use of hand hygiene was implemented during the resident's dinning These deficient practices had the potential to result in cross-contamination of infections from patient equipment, staff to the residents, as well as resident to staff, and resident to resident. Findings: a. A review of Resident 4's Admission Face Sheet indicated the resident was admitted to the facility on [DATE] with an original admission date of [DATE]. Resident 4's [DIAGNOSES REDACTED]. A review of Resident 4's history and physical assessment form dated 2/26/2020 indicated the resident had the capacity to understand and make decisions. A review of resident 4's physician orders [REDACTED]. daily by mouth for diabetes with meals, and [MEDICATION NAME] (decreases the amount of acid produced in the stomach) 40 mg by mouth before breakfast. A review of Resident 4's Minimum Data Set (MDS), a standardized assessment and care screening tool dated dated [DATE], indicated the resident was able to understand and be understood by others. The MDS indicated Resident 4 had difficulty communicating some words and thoughts needing prompting or time to complete expressions. The MDS indicated Resident 4 required a one person's assistance with bed mobility, transfer, moving from one location to another, dressing, eating, toilet use and personal hygiene. The MDS also indicated Resident 4 was receiving [MED] (medication to treat diabetes). On 3/7/20 during medication pass observation, Licensed Vocational Nurse (LVN 3) used a blood pressure cuff on Resident 4, without first conducting hand hygiene, and without cleaning the blood pressure cuff before and after its use. On 03/07/20 at 12:44 p.m., during an interview, LVN 3 acknowledged that after checking Resident 4's blood pressure, the cuff should have been disinfected and hand hygiene performed before administering medications to prevent infection and cross contamination of germs from one resident to another. On 03/08/20 at 05:58 a.m., during a concurrent medication pass observation and interview, LVN 4 cleaned a medication tray, dispensed [MEDICATION NAME] 40 mg then proceeded to administer the medication to the resident without performing hand hygiene. LVN 4 stated hand hygiene should have been prepared before and after preparing medications to prevent infection. A review of facility's policy and procedure titled Handwashing/Hand Hygiene dated 4/2012, indicated all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy indicated hand hygiene products and supplies (sinks, soap, towels, alcohol -based hand rub, etc) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene polices. b. On 03/07/20 at 12:15 p.m., during dining observation, Licensed vocational Nurse (LVN 6) wiped the resident's hands with a hand sanitizer wipe. LVN 6 used one hand sanitizer to wipe clean the left hand, and used the same hand sanitizer to wipe the right hand, using bare hands. During concurrent dining observation Certified Nurse assistant (CNA 1) was observed using one sanitizer wipe on another resident's hands, while sitting at the dining table, with an ungloved hands. On 03/07/20 at 12:30 p.m., during interview LVN 6 acknowledged and stated I have worked in the facility since October 2019. This is considered as a cross contamination. There was only one sanitizer wipe for resident, that was why I used one to wipe for both hands. I will let kitchen know so that they can add more than one on resident trays. On 3/7/20 at 3:11 p.m., during interview Director of Staff Development (DSD) stated From my previous experience the best way to sanitize residents hands is for the staff to glove and use one wipe sanitizer, wipe down and discard, and use another wipe sanitizer for the other hand. Using one hand sanitizer for both hands was a cross contamination. I will provide one on one in-service for both staffs, so that it will not happen again. On 03/07/20 at 04:45 p.m., during interview LVN 5, who was the designated Infection Control Nurse, stated We provided the hand sanitizer wipes because of the current coronavirus (virus associated with severe respiratory illness) incident. We have a box of hand sanitizer wipes. It was not as a result of shortage. We have to provided education, that was cross contamination of residents. The correct way is to gel in, and gel out. We educate the staff to either wash the resident's hands or use gel after care. A review of facility's policy and procedure titled Handwashing/Hand Hygiene dated 4/2012, indicated all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy indicated hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene polices.