STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR GLEN CARE CENTER	**1033 E. ARROW HIGHWAY GLENDORA, CA 91740**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to respect the resident's right to dignity and respect by not knocking before entering the restroom in use and room, for one out of three sampled residents (Resident 8). This deficient practice had the potential to cause psychosocial harm, anxiety, fear, embarrassment and lowered self-esteem for Resident 8. Findings: A review of Resident 8's Face Sheet dated 2/7/20, indicated the facility admitted the resident 8 on 1/24/20 with [DIAGNOSES REDACTED]. A review of Resident 8' History and Physical (H&P) dated 1/27/20, indicated the resident had the capacity to understand and make decisions. A review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 1/31/20, indicated the resident required extensive assistance with toileting and walking in room. During an observation on [DATE] at 12:50 pm, Certified Nurse Assistant 2 (CNA 2) took a urinal from Resident 8's roommate and entered the restroom without knocking. Resident 8 was observed by surveyor seated on the toilet in the restroom. Concurrently, Resident 8 yelled at CNA 2, hey, that's why you knock. During an interview on [DATE] at 12:52 pm, CNA 2 stated it was important to knock before entering the restroom to respect the resident's right, privacy and dignity. During an observation on [DATE] at 12:53 PM, CNA 2 entered Resident's room and placed the resident's lunch tray on a bedside table without knocking. A review of the facility's policy titled Dignity and Respect with a revised date of 5/2019, indicated privacy of a resident's body should be maintained during toileting, bathing ad other activities of personal hygiene.
F 0580 **Level of harm** - Actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to notify the physician of a significant change in potassium and sodium levels (also known as electrolytes which are minerals that are involved in many essential processes in the body. Potassium affects the heart function and sodium affects the brain function) for one out of two sampled residents (Resident 1). The facility did not notify Resident 1's attending physician of the resident's high potassium level and low sodium level on the laboratory report. The facility could not produce documentation the licensed nurses informed Resident 1's attending physician of the potassium and sodium levels. The licensed nurses did not recognize that high levels of potassium and low levels of sodium were life threatening. These deficient practices resulted in delayed care for Resident 1. A certified nursing assistant (CNA) found Resident 1 unconscious inside her room on [DATE]. The facility staff (not able to identify) performed cardiopulmonary resuscitation (CPR, an emergency procedure that combines chest compressions often with ratification ventilation in an effort to manually preserve the brain function in a person with cardiac (heart) arrest (stop)) on the resident and called 911 (a telephone number for an emergency service). Resident 1 was transported to the general acute care hospital (GACH) and was admitted into intensive care unit (ICU). Resident 1 was found to have a high potassium level and low sodium level. Resident 1 died on [DATE]. Findings: A review of Resident 1's Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and was re-admitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE], indicated the resident needed extensive assistance with bed mobility, dressing, and toilet use. The MDS indicated Resident 1 was totally dependent on others for eating and personal hygiene. A review of Resident 1's History and Physical (H&P) dated [DATE], indicated the resident did not have the capacity to understand and make decisions. A review of Resident 1's Comprehensive Metabolic Panel (CMP, a blood test that measures blood sugar levels, electrolyte and fluid balance, kidney and liver function) dated [DATE] at 4:50 am, indicated an elevated potassium blood level of 5.8 (normal range is 3.5 to 5.5) milliequivalents per liter (meg/L, a unit of measure). The CMP also indicated Resident 1's blood sodium level was low at 121 meq/L (normal range is ,[DATE]). A review of Resident 1's Progress Notes dated [DATE] at 2:31 pm, the progress note indicated the resident's attending physician (AP 1) was informed of lab results and an order was given to increase continuous flushing due to elevated blood urea nitrogen level (BUN, a test how well the kidneys are working). The note did not indicate if AP 1 was informed of potassium or sodium level. A review of Resident 1's Interdisciplinary Team (IDT, a team of health care professions, who work together to establish plans of care for residents) meeting dated [DATE] at 9:34 am, indicated the IDT was held as a quarterly review. The IDT did not address any lab levels or recent [DIAGNOSES REDACTED]. A review of Resident 1's Comprehensive metabolic panel (CMP) dated [DATE] at 5:30 am (on [DATE] at 10:39 am, the Director of Nursing Designee stated, during an interview, the CMP report should have a date of [DATE]), indicated Resident 1 had an elevated potassium blood level of 6.9 meq/L . The CMP also indicated Resident 1's blood sodium level was 110 meq/L. A review of Resident 1's Progress Notes dated [DATE] at 4:49 pm, indicated AP 1 went to the facility to see the resident. The note indicated no new orders were given and to continue the plan of care. The note did not indicate if the licensed nurses addressed the potassium or sodium levels with AP 1. The potassium and sodium levels were not reported to the physician. A review of Resident 1's Progress Notes dated [DATE] at 12:30 am, indicated that on [DATE] at 8:45 pm, Resident 1 was found by a CNA breathing abnormally. The note indicated a charge nurse and nurse supervisor went to Resident 1's room where they found her unconscious. The note indicated Resident 1 was observed to gasp for air twice and then stopped breathing, then CPR was performed and 911 called. The note indicated Resident 1 was transported to the emergency room (ER) by paramedics. A review of the GACH ED General note dated [DATE], indicated Emergency Medical Services (EMS) staff reported they achieved the return of a cardiac rhythm (the heart beat again) which indicated the resident had suffered a [MEDICAL CONDITION] (occurs when the flow of blood to the heart is blocked). Resident 1 arrived at the ED at 9:44 pm, blood work indicated Resident 1's potassium level was 8.3 meq/L, sodium level 108.0 meq/L, and ionized calcium 0.8 mmol/L (1XXX,[DATE].32) (ionized calcium is a mineral and is tested if the person showed signs of kidney disease). The GACH impression indicated Resident 1 suffered a [MEDICAL CONDITION] which lead to cardiopulmonary (heart and lungs) arrest (to stop). At 9:47 pm Resident 1's heart stopped again; ED staff were unable to resuscitate Resident 1. Resident 1 was pronounced dead at 10:23 pm. A review of Resident 1's Certificate of Death, indicated Resident 1 died on [DATE] at 10:03 pm. The immediate causes of death indicated were cardiopulmonary arrest and [MEDICAL CONDITIONS] (narrowing of the arteries (blood vessels that carry [MED]gen and nutrients to the heart) caused by buildup of plaque). During an interview on [DATE] at 10:39 am, the Director of Nursing Designee (DOND) stated changes in condition (COC) included abnormal labs. The DOND stated when a COC happens, the Director of Nursing (DON) collaborates with the IDT and physician to update the plan of care as needed. It is then the DON's responsibility to follow up and make sure

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 0580 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) everything is implemented. The DOND stated if the physician does not act on any COC, it is the DON 's responsibility to double check the accuracy of assessments and document the findings in the medical record. During a concurrent interview and closed record review of the CMP report dated [DATE] with the DOND, on [DATE] at 1:15 pm, the DOND stated a high potassium level could cause arrythmias (irregular heart beat) and cardiac (heart) arrest. The DOND stated the progress notes on [DATE] indicated the physician was made aware of labs but the notes did not specify which labs were told to the physician. The DOND stated the physician wrote an order to address the elevated BUN, but the potassium was not addressed and should have been. The DOND stated the licensed nurses should know the significance of potassium and a 5.8 meq/L potassium level should have raised a flag (alert as a potential danger or trouble) and something should have been done. During the same concurrent interview and closed record review on [DATE] at 1:15 pm, the DOND stated on [DATE], the physician went to the facility to see Resident 1 and the resident's potassium level was not addressed. The DOND stated that was another opportunity to do so but it was not, and no documentation addressing potassium was entered in Resident 1's medical record. The DOND reviewed the resident's potassium level collected on [DATE] at 5:30 am, the DOND stated the level of 6.9 meq/L meant a [MEDICAL CONDITION] would happen. The DOND stated the date collected should have read [DATE] because the Resident expired on the 19th. The DOND stated lab results are usually received around 3 pm via fax but the nurses have access to them earlier via computer access. During the same concurrent interview and closed record review on [DATE] at 1:15 pm, the DOND stated and confirmed no action was taken by the facility, nor documentation was made regarding the resident's potassium level until 8:45 pm (on [DATE]) in which the resident was found needing CPR and a transfer to the hospital. The DOND stated if the labs were addressed on [DATE], Resident 1's death could have potentially been avoided by lowering the risks of [MEDICAL CONDITION]. The DOND stated the facility should have advocated for Resident 1 and confirmed no action was taken by the facility on [DATE] when Resident 1's potassium was noted to be high, and that the resident's potassium was not addressed at all after that. During a telephone interview on [DATE] at 9:18 am, Resident 1's attending physician (AP 1) stated he had cared for Resident 1 for many years and remembered her case in detail. AP 1 stated he went to the facility to examine Resident 1 once a month. AP 1 stated his exams of Resident 1 consisted of a physical exam, vital signs review, listening to the heart and lung sounds, and a chart review. AP 1 stated he relied on the facility to monitor the resident and inform him of any declines in condition. AP 1 stated if a lab is abnormal or if a resident is not doing well, it is the responsibility of the facility to report it immediately to the physician. AP 1 stated it was then the responsibility of the facility to call him and document conversation and new orders in detail in the resident's medical record. During the telephone interview on [DATE] at 9:18 am, AP 1 stated he did not remember the facility ever notifying him of Resident 1's critical potassium level of 5.8 meq/L on [DATE]. AP 1 stated that was a critical lab (laboratory result) requiring a redraw to confirm level, administration of [MEDICATION NAME] (a medication used to remove excess potassium from the body), and a transport to the emergency room . AP 1 stated he did not remember the facility ever notifying him of Resident 1's critical potassium level of 6.9 meq/L on [DATE] (per the DOND on [DATE] at 1:15 pm, the correct laboratory report date should have been [DATE]). AP 1 stated a level that high could cause cardiac arrhythmias (irregular heart rhythm) and [MEDICAL CONDITION] (the heart to stop beating). AP 1 state he was not notified of the sodium level of 121 meq/L on [DATE] or the sodium level of 110 meq/L on [DATE] (per the DOND on [DATE] at 1:15 pm, the correct laboratory report date should have been [DATE]). . During the telephone interview on [DATE] at 9:18 am, AP 1 stated those levels required treatment at a higher level of care (ER), and a sodium imbalance could disrupt the entire body physiology. AP 1 stated if a lab is not available for the physician or overlooked by the physician when visiting the resident, it is the nurse's responsibility to inform the doctor ,it is by law. AP 1 stated it is their (facility licensed nurses) job; they must address the abnormal labs. AP 1 stated he expects the facility staff to advocate for residents and let him know, he only goes to the facility on ce a month and does not have access to labs from his office, the nurses are always there. AP 1 stated if the nurse's feel a lab or medication need to be ordered or adjusted the nurses are responsible to call the doctor. A review of the facility's policy titled care and treatment: Significant Change in Condition and Monitoring, communication, 24 hours chart check and endorsement between shift with a revised date of ,[DATE], indicated if at any time a facility staff member identify a change in the care needs of a resident the nurse supervisor was to be made aware. Reasons that changes in care may be needed included change in mental status, signs and symptoms of infection. The policy indicated that there would be ties where immediate attention would be warranted and nursing was responsible for notifying appropriated departments. The policy indicated the physician, resident, and responsible party would be notified of significant changes in condition. A review of the facility's policy titled Resident Rights: Notification, Physician or Responsible party with a revised date of ,[DATE], indicated nurse supervisors were to notify the attending physician when there was a significant change in condition or if it was deemed necessary or appropriate in the best interest of the resident.
F 0693 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure three of eight sampled residents (Residents 1, 4 and 6) receiving enteral feedings (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) received appropriate care and services. These deficient practices included: 1. A licensed nurse used a declogger (a mechanical device used to remove an accumulation of matter in the [DEVICE]) on Resident 4's gastrostomy ([DEVICE]), a tube surgically placed into the stomach, which allows for nutrition and medications). The licensed nurse had never used the declogger device before and had not received training on how to use a declogger. 2. Resident 1 went to the hospital 11 times, within 16 months, for a clogged and leaking gastrostomy tube ([DEVICE]). There was no indication of the cause for Resident 1's [DEVICE] issues and hospitalization s. 3. During a medication observation, a licensed nurse administering nine medications through Resident 6's [DEVICE] without administering water between each medication. During the same medication observation, the licensed nurse administered [MEDICATION NAME] without stopping the enteral feeding one hour before and after the administration for absorption purposes. The licensed nurse stated water flushes are not necessary and only done prior to medication administration and after the last medication is administered through the [DEVICE]. On [DATE] at 2:40 p.m., the Department of Public Health called an Immediate Jeopardy situation (IJ), a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the administrator. These failures include: 1. Licensed nurses' use of a declogging device on Resident 4's [DEVICE], twice, without knowledge or training on how to use the declogging device, without following the manufacturer's instructions or manual, and without a physician's orders [REDACTED]. Additionally, the licensed nurse did not stop Resident 6's continuous tube feeding one hour prior to and after administering the [MEDICATION NAME] medication. These practices did not ensure Resident 1 absorbed the correct dose of [MEDICATION NAME]. On 2/8/2020 at 1:16 p.m., the administrator provided an acceptable written plan of action (POA) that included the following summarized actions: In-services given by a clinical consultant and pharmacy staff, to the licensed nursing staff regarding: 1. Gastrostomy tube placement, management, care, emphasizing declogging and the facility's policy revision on steps to take to declog a [DEVICE] and inclusion of a performance skills checklist for each licensed nurse. 2. Removal of all declogging devices from the facility's supply room and will no longer be available. 3. Medication administration, which included medication rights, [MEDICATION NAME]es, liquid medications, and an emphasis on enteral medication administration, which also included placement verification. On 2/08/20 at 1:16 p.m., while onsite and after verifying and confirming the facility's implementation of the immediate corrective actions (POA), the Department removed the Immediate Jeopardy, in the presence of the administrator. Findings: On 2/6/20 at 5:08 a.m., the Department made an onsite visit to the facility. During an observation and tour of the facility on 2/6/20 at 5:16 a.m., residents of the facility were in their rooms. Two licensed nurses were in the hallways in Stations 2 and 3, at the medication carts, preparing to administer medications to the residents. 1. During an observation on 2/6/20 at 5:26 a.m., Resident 4 was lying in bed asleep with the head of the bed elevated to approximately 20 degrees. There was a continuous formula feeding of Glucerna (a calorically dense formula used to minimize elevated blood sugar levels) connected to the resident's [DEVICE] port infusing at 50 milliliters ((mL) a unit of measure) per hour (mL/hr, the amount of formula over an hour). A review of Resident 4's Face Sheet indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's History and Physical (H&P) dated 1/09/20, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 1/15/20,

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F 0693 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) indicated Resident 4 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. During an observation of a [DEVICE] feeding change on 2/6/20 at 5:26 a.m., Licensed Vocational Nurse 4 (LVN 4) stated and confirmed the formula feeding was infusing at 50 mL/hr. LVN 4 stated, I saw the MD (medical doctor) order and it was different. It should have been set at 70 mL/hr. LVN 4 proceeded to change infusion rate on Resident 4's feeding pump. LVN 4 then disconnected the feeding from the resident's [DEVICE] and injected 10 mL of air into [DEVICE] port, but the air would not go into the tube. LVN 4 stated he needed to flush [DEVICE] first. LVN 4 did not check the [DEVICE] for any residual. LVN 4 placed 30 mL into a large syringe (a 60 mL syringe that enables tube feeding and water flushes) and attached the syringe to Resident 4's [DEVICE] port. LVN 4 raised the [DEVICE] and syringe to allow water to flow in by gravity, but the water did not enter the [DEVICE]. LVN 4 then began squeezing the entire [DEVICE] connected to the resident. LVN 4 stated, The tubing felt squishy and was milking it (squeezing the tubing) to unclog it. LVN 4 continued to squeeze the entire tubing and pull at tubing while doing so. An abdominal binder (an elastic abdominal support band) was over the entry point of [DEVICE]. LVN 4 pulled and squeezed the [DEVICE] with enough force to cause the binder to lift away from Resident 4's abdomen. On 2/6/20 at 5:55 a.m., during an observation and interview, LVN 4 stated he needed to grab a declogger located in the facility's supply room. LVN 4 went to the facility's supply room, where he grabbed two long declogger packages. At 6 a.m., LVN 4 entered Resident's 4 room and applied gloves without performing hand hygiene. LVN 4 opened the declogger package, removed the declogger device, and discarded the packaging in the trash can. LVN 4 did not read the packaging instructions and began inserting the declogger, a long light blue flexible plastic stick, approximately 16 inches long, into Resident 4's [DEVICE]. After fully inserting the declogger into the [DEVICE], LVN 4 began twisting the declogging device in a right and left twisting motion while squeezing and milking the [DEVICE]. During an observation and interview, on 2/6/20 at 6:09 a.m., LVN 4 stated he needed to use another declogger and tried again. LVN 4 again opened the declogger packaging, removed the declogger and discarded the packaging, with the instructions into the trash can. LVN 4 then reinserted the declogger into Resident 4's [DEVICE] using the same twisting motion while squeezing and milking the [DEVICE]. At 6:20 a.m. LVN 4 removed the declogger, threw it away in the trash can. LVN 4 proceeded to the restroom and obtained warm water from the sink. LVN 4 then placed 30 mL of water into a syringe and attached it to Resident 4's [DEVICE]. LVN 4 began forcefully pushing on the plunger trying to inject water into [DEVICE] multiple times. At 6:25 a.m., after two unsuccessful attempts with the decloggers and three unsuccessful attempts with the warm water, LVN 4 stated he would go to doctor's room and ask the physician's assistant (PA) what he should do. LVN 4 returned and stated the PA told him to get another nurse to try. During an observation on 2/6/20 at 6:40 a.m., LVN 5 entered Resident 4's room without knocking or performing hand hygiene. LVN 5 put on gloves and began to release Resident 4's abdominal binder. LVN 5 instructed LVN 4 to push the water in Resident 4's [DEVICE] as LVN 5 squeezed the entire length of the G-tubing. After a few attempts, LVN 4 was able to inject 30 mL of water throughout Resident 4's [DEVICE]. During an interview, on 2/6/20 at 7 a.m., LVN 4 stated he had pre documented Resident 4's [DEVICE] feeding change at 4 a.m. instead of the actual time of 6:44 a.m. LVN 4 stated documentation should be done in real time in case something happens. LVN 4 also stated the feeding was infusing at a lower rate than ordered by the physician. Resident 4 did not receive feeding for 1.5 hours while he tried to unclog the [DEVICE]. LVN 4 stated this could lead to Resident 4 being malnourished. LVN 4 added he did not document declogging the [DEVICE] because there was no place to do so. LVN 4 stated he never received any training on declogging the [DEVICE] and this was his first time using the declogger. LVN 4 stated he saw the declogging device in the supply room, so he thought he would use it. LVN 4 stated he did not know the policy on declogging and did not know where any of the facility's policies were located. LVN 4 stated it was important to have access to policies so he would know how to do his job and provide the best care. LVN 4 stated the facility never trained him to check for residual in the [DEVICE] and he just thought he needed to inject air to check for [DEVICE] placement. LVN 4 continued that he was not sure how to unclog a [DEVICE] so he guessed he could squeeze and pull on the [DEVICE] in an up and down motion. LVN 4 stated pulling on the [DEVICE] could cause displacement or dislodgement (removal). LVN 4 stated by forcing water into the [DEVICE] with the syringe could have burst or rip the [DEVICE]. A review of Resident 4's Progress Notes dated 2/6/20 indicated LVN 4 did not document trying to unclog the [DEVICE] with the declogging device or consultation with the physician's assistant During an interview on 2/06/20 at 12:48 p.m., the Director of Nursing (DON) stated she could not locate a policy for the declogging device. The DON stated and confirmed LVN 4 did not document the attempts at declogging the [DEVICE] or consultation with the physician assistant (PA) in Resident 4's medical record. The DON stated it is a standard of practice to document as documentation is used as a communication tool between the staff members and the physician. During a concurrent interview and observation, on 2/6/20 at 1:11 p.m., LVN 6 entered the supply room, a box of 10 decloggers were packaged in a box on the shelf. There were six decloggers remaining in the box. LVN 6 stated she was never trained on how to use the declogger devices. LVN 6 stated she observed the declogger being used once during her orientation by another nurse. LVN 6 stated she did not know if there was a policy for the decloggers and did not know how to use the declogging device. A review of Resident 4's progress notes, dated 2/6/20 at 4:08 p.m., indicated LVN 4 used a declogger on Resident 4's [DEVICE] at approximately 6 a.m. The progress notes indicated the licensed nurse did not obtain a physician's orders [REDACTED]. The progress notes also indicated the licensed nurses are not professionally trained in the use of the declogging device. The American Society for [MEDICATION NAME] and Enteral Nutrition (ASPEN) recommends warm water as the best initial choice for trying to unclog a feeding tube. Additional second-line interventions include using a commercially available enzyme declogging kit or mechanical declogging device. These also must be used in accordance with facility policy and procedure and only by experienced clinicians . Nursing2019: June 2018 - Volume 48 - Issue 6 - p 66 doi: 10.1097/01.NURSEXXX XXX .5e 2. A review of Resident 1's Face Sheet in the closed record indicated an initial admission to the facility on [DATE] and a re-admission on 11/27/19. Resident 1's [DIAGNOSES REDACTED]. A closed record review of Resident 1's Minimum (MDS) data set [DATE] indicated Resident 1 was dependent on others for eating and personal hygiene. A closed record review of Resident 1's History and Physical (H&P) dated 11/30/19, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's closed record indicated 17 transfers from the skilled nursing facility to the general acute care hospital (GACH) from 1/08/18 to 12/20/19. Eleven of the 17 hospitalization s were for Gastro-Jejunal (GJ) Tube (a tube, surgically placed, into the stomach (G-port) and the small intestine (J-port), which allows for nutrition and medications) blockage, leakage, rips, or tears on 6/26/28, 7/19/18, 12/30/18, 12/31/18, 1/03/19, 1/18/19, 1/2[DATE]9, 3/30/19, 4/5/19, 6/6/19, and 10/13/19. A closed record review of Resident 1's care plan for alteration in gastrointestinal (stomach and small and large intestines) status dated 12/30/18 and revised on 1/15/19 indicated Resident 1 had a dislodged GJ-tube. The interventions indicated to transfer the resident to a general acute care hospital. There were no other revisions indicated. A review of Resident 1's care plan, in the closed record, for tube feeding dated 1/7/19 indicated Per the physician, expected leakage due to stoma being bigger than GJ-tube outlet. There were no care plan interventions created. Another review of Resident 1's care plan, in the closed record, for potential for fluid deficit/dehydration related to nausea and GJ-tube feeding revised on 12/2[DATE]8 indicated to monitor and document the intake and output as per facility policy. Another intervention indicated to report any signs or symptoms of dehydration (a harmful reduction in the amount of water in the body) to the physician. A review of Resident 1's skilled nursing facility progress notes, in the closed record, dated 12/30/18 at 4:09 p.m., documented Resident 1 had returned from the hospital to the facility with GJ-tube intact, no residual (the amount of formula left in the stomach), or redness noted. Another progress note dated 12/30/18 at 8:30 p.m., indicated leakage from Resident 1's GJ-tube and soiling on the gauze dressing, surrounding the GJ-tube. The progress note indicated to transfer Resident 1 to GACH. A review of Resident 1's skilled nursing facility progress notes, in the closed record, dated 3/30/19 at 10 p.m., indicated Resident 1 received medication via the GJ-tube at 5 p.m. The progress note indicated at 8 p.m. a licensed nurse found the GJ-tube port open with fluid back flowing. The progress note indicated three nurses attempted to flush the clogged line unsuccessfully. Resident 1 required a transfer to GACH for a clogged GJ-tube. 3. During an observation on 2/6/20 at 8:17 a.m., Resident 6 was lying in bed, with the head of bed elevated, and a continuous feeding of Glucerna 1.2 calories (cal) infusing at 70 milliliter per hour (mL/hr.) via the [DEVICE]. A review of Resident 6's Face Sheet indicated an admission to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident 6's history and physical examination [REDACTED]. A review of Resident 6's Minimum Data Set, dated dated [DATE], indicated Resident 6 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. During a medication administration observation on 2/6/20 at 9 a.m., LVN)1 paused Resident 6's continuous feeding immediately prior to checking the placement of the [DEVICE]. LVN 1 injected 30 mL of air with a 60 mL syringe into Resident 6's [DEVICE] while auscultating (listening) with a stethoscope. After validating hearing the placement of Resident 6's [DEVICE], LVN 1 aspirated 30 mL of gastric residual. LVN 1 initiated the medication administration to Resident 6 by pouring 40 mL of water into a syringe attached to the [DEVICE]. The licensed nurse

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F 0693 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) administered nine medications including [MEDICATION NAME] (a medication used to prevent [MEDICAL CONDITION]) 15 mL through Resident 6's [DEVICE]. LVN 1 did not flush water between each of the nine medication administered. After administering all of Resident 6's medications, LVN 1 flushed the [DEVICE] with 40 mL of water and immediately resumed Resident 6's continuous feeding of Glucerna. During an interview, on 2/6/20, at 9:30a.m., LVN 1 stated she did not perform a flush of water between each of Resident 6's medications. LVN 1 stated a water flush is not necessary and only done prior to medication administration and after the last medication is administered. LVN 1 stated she monitors the [DEVICE], the gastric residual, drainage from the [DEVICE] site and the resident's discomfort. During a concurrent interview and record review on 2/6/20, at 2:07 p.m., of Resident 6's February 2020 Medication Administration Record [REDACTED]. LVN 1 stated she did not receive any training on flushing water in between each medication via the [DEVICE]. LVN 1 stated she follows the physician orders [REDACTED]. LVN 1 added when giving Resident 6's [MEDICATION NAME] suspension there were no special instructions prior to administering [MEDICATION NAME]. LVN 1 stated Resident 6 receiving continuous feeding that ends at 10 a.m. and resumes at 2 p.m., for a total of 20 hours. LVN 1 could not state the importance of not administering [MEDICATION NAME] while infusing the continuous feeding. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. LVN 1 stated, I messed up. During an interview on 2/6/20, at 2:20 p.m., the DON stated when administering medications to a resident with a [DEVICE], 5-10 mL of water should be flushed between each medication. The DON stated if the licensed nurse did not flush between medications, the medication would not completely dissolve and this could increase the risk for clogging the [DEVICE]. The DON stated [MEDICATION NAME] is a medication for [MEDICAL CONDITION] and if a resident was on a continuous feeding pump, then the licensed nurse should stop the feeding for one hour prior to and after administering the medication for absorption purposes. The DON stated if the licensed nurse did not stop the tube, feeding this could increase the chance the resident would experience of [MEDICAL CONDITION]. During a concurrent interview and closed record review on 2/11/20 at 11:47 a.m., the director of nurses' designee (DOND) stated to hospitalize a resident so many times for GJ-tube issues is inappropriate. The DOND also stated and confirmed there was no documentation in the medical record indicating Resident 1 pulled on the GJ-tube therefore it was the director of nurses (DON's) responsibility to find the root cause for all the [DEVICE] issues, such as being pulled out while turning or providing care for the resident. The DOND also stated and confirmed the nursing staff left Resident 1's GJ-tube port open on 3/30/19, causing the tube to clog and requiring the resident to go to the GACH. During a concurrent interview and closed record review on 2/11/20 at 11:47 a.m., the DOND stated a lack of nurses' competency could be a cause requiring all of Resident 1's transfers to GACH for GJ-tube issues, especially when there were rips and tears. The DOND stated the rips/tears could have only been caused by an external factor such as the tube not being flushed or handled correctly. The DOND stated documentation throughout Resident 1's medical record did not detail the condition of the GT-tube and should have prompted further investigation. The DOND stated prolonged issues with a GJ-tube could lead to malnourishment, infections, and dehydration, which could lead to [MEDICAL CONDITION] and be fatal. During an interview, on 2/6/20, at 9:58 a.m., the assistant director of nurses (ADON) stated the declogging devices were in central supply and any licensed nurse could use the declogger. The ADON initially stated uncertainty about needing a physician's orders [REDACTED]. The ADON stated before using a declogger, the licensed nurse notifies the physician followed by a physician's orders [REDACTED]. The ADON further stated the declogger was the last option to unclogging a [DEVICE], the first intervention is warm water. During an interview on 2/6/20, at 1:18 p.m., the Director of Nurses (DON) stated the licensed nurses could use a declogger to unclog a [DEVICE]. The DON stated the declogger was part of central supply and was unsure if the use requires a physician's orders [REDACTED]. The DON was unable to provide the manufactures instructions or manual for the use of the declogger. During an interview on 2/6/20, at 1:38 p.m., the Director of Staff Development (DSD), stated, when checking for placement of a [DEVICE], an air-filled syringe attaches to the [DEVICE] and the licensed nurse slowly injects air into the [DEVICE]. Then the licensed nurse aspirates (withdraws) gastric (stomach) residual. The DSD stated when a [DEVICE] becomes clogged, warm water flowed by gravity is placed into the [DEVICE], if the [DEVICE] was still clogged the licensed nurse notifies the physician and the resident goes to the hospital. The DSD stated occasionally a declogger is used but should have a physician's orders [REDACTED]. The DSD stated there is potential the declogger could perforate the [DEVICE], cause a tear, or could become stuck inside the [DEVICE]. The DSD stated she had never received any training on how to use the declogger and provided inservices based on the packaging instructions. During an interview on 2/7/20 at 1:15 p.m., the DON stated the use of a declogger could cause nausea and vomiting, cramping, pain, trauma to the lining in the stomach, and could potentially poke a hole in something. The DON stated she was sure what part of the anatomy could be poked. The DON stated the facility used the decloggers before she was employed (April 2018) and she had never received any training on the decloggers. The DON confirmed the facility did not request physician's orders [REDACTED]. We identified the deficient practice yesterday. A review of the facility's policy, titled, Gastrostomy Tube, revised on 5/2019, indicated to Flush the [DEVICE] with 5-10 mL of water after administering each medication. If a [DEVICE] clogs, Never insert a device into a gastrostomy tube. A review of the facility's policy titled, Gastrostomy tube revised on 5/2019 indicated it was the policy of the facility to provide proper care and maintenance of a [DEVICE]. The policy indicated there was a daily checklist for [DEVICE]s, which included checking for pain, checking the tube exit site, rotating the tube and external bolster turn, daily cleaning of stoma sites, verifying position before every feeding, and flushing the feeding tube and adapter every four hours per physician's orders [REDACTED]. of procedure. A review of the facility's policy titled Licensed Nurse Procedures: Enteral Tube - Patency Check with a revised date of 5/2007, indicated it was the policy of the facility to ascertain the feeding tube was in the proper place and patent (open). The policy indicated patency checks needed to be done and documented every eight hours in the progress notes.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure licensed nurses were competent to assess, care for, insert and maintain gastrostomy tubes ([DEVICE], a device placed into the stomach for nutrition, hydration and medication) for three out of eight sampled residents (Resident 1, 4 & 6). These deficient practices included: 1. A licensed nurse used a declogger (a mechanical device used to remove an accumulation of matter in the gastrotomy ([DEVICE])) on Resident 4's [DEVICE], a tube surgically placed into the stomach, which allows for nutrition and medications). The licensed nurse had never used the declogger device before and had not received training on how to use a declogger. 2. Resident 1 went to the hospital 11 times, within 16 months, for a clogged and leaking gastrostomy tube ([DEVICE]). There was no indication of the cause for Resident 1's [DEVICE] issues and hospitalization s. 3. During a medication observation, a licensed nurse administering nine medications through Resident 6's [DEVICE] without administering water between each medication. During the same medication observation, the licensed nurse administered [MEDICATION NAME] without stopping the enteral feeding one hour before and after the administration for absorption purposes. The licensed nurse stated water flushes are not necessary and only done prior to medication administration and after the last medication is administered through the [DEVICE]. Findings: On 2/6/20 at 5:08 am, an unannounced onsite visit was conducted at the facility to investigate a complaint. a. Resident 1's Face Sheet, indicated the facility initially admitted the resident on 8/12/15, and readmitted the resident on 11/27/19 , with [DIAGNOSES REDACTED]. Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE], indicated the resident required extensive assistance with bed mobility, dressing, toilet use and was dependent on others for eating and personal hygiene. Resident 1's History and Physical (H&P) dated 11/30/19, indicated the resident did not have the capacity to understand and make decisions. Resident 1's Nursing home to Hospital transfer forms dated from 1/08/18 to 12/20/19, indicated that the resident was hospitalized 11 out of these 17 times for Gastrojejunostomy (G/J, a surgical formation of a passage between the stomach and jejunum (part of the small intestine) tube blockage, leakage and or rips/tears on: 6/26/28 7/19/18 12/30/18 12/31/18 1/3/19 1/18/19 1/2[DATE]9 3/30/19 4/5/19 6/6/19 10/13/19 Resident 1's initial Interdisciplinary Team (IDT, a team of health care professions, who work together to establish plans of care for residents) meeting dated: 1/19/18 12/13/18 2/12/19, 3/1[DATE]9, 6/13/19, 9/19/19 and 12/18/19, indicated Resident 1 required feedings through a G tube. However the same IDT, did not address the resident's rehospitalization s due to and or necessary interventions to prevent the G/J tube issues for Resident 1. A review of Resident 1's care plan dated 12/30/18, 1/7/19 and 12/2[DATE]9, indicated to transfer the resident to a GACH for dislodged, leaking [DEVICE], and with no other interventions. A review of Resident 1's care plan on tube feeding dated 1/7/19, indicate per the physician, expected leakage due to stoma being bigger than G tube outlet . However there were no

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	056360	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

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 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) interventions for expected [DEVICE] leakage. A review of Resident 1's care plan for potential for fluid deficit/dehydration related to nausea and G tube feeding with a revision date of [DATE] indicated interventions which included monitoring and documenting the intake and output as per facility policy, and monitoring, documenting, and reporting any signs or symptoms of dehydration to the physician. A review of Resident 1's Progress notes dated 12/30/18 at 4:09 pm, indicated the G tube was intact, when the resident returned to the facility. A review of Resident 1's Progress notes dated 3/30/19 at 10:00 pm, indicated the resident received medication via the G tube at 5:00 pm. At 8:00 pm, the J port on the [DEVICE] was open with fluid back flowing. Three nurses attempted were not able to declog the resident's [DEVICE] and the resident was transferred to GACH. During an interview on 2/11/20 at 11:47 am, the Director of Nursing (DON) stated Resident 1 was pulling out the [DEVICE] and it was not appropriate for the resident to be hospitalized severally due to G tube issues. On a concurrent record review, the DON stated there was no documentation Resident 1's medical records to indicate the resident was pulling on the G tube. The DON stated Resident 1's G/J tube port left open, failure to flush and incorrect handling could result in clogging, tears and rips of the G/J-tube. The DON stated Resident 1's [DEVICE] clogged on 3/30/19 which resulted in the resident's transfer to GACH. The DON stated a lack of competence could have been a cause requiring all of Resident 1's transfers to GACH for G tube issues, especially when there were rips and tears. The DON stated repeated and prolonged G/J tube issues could result in Resident 1's poor nutrition, infections, dehydration, [MEDICAL CONDITION] and or death. b. A review of Resident 4's Face Sheet indicated an admission to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's History and Physical (H&P) dated 1/9/20, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 1/15/20, indicated Resident 4 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. During an observation of a [DEVICE] feeding change on 2/6/20 at 5:26 a.m., Licensed Vocational Nurse 4 (LVN 4) stated and confirmed the formula feeding was infusing at 50 ml/hr. LVN 4 stated, I saw the MD (medical doctor) order and it was different. It should have been set at 70 ml/hr. LVN 4 proceeded to change infusion rate on Resident 4's feeding pump. LVN 4 then disconnected the feeding from the resident's [DEVICE] and injected 10 ml of air into [DEVICE] port, but the air would not go into the tube. LVN 4 stated he needed to flush [DEVICE] first. LVN 4 did not check the [DEVICE] for any residual. LVN 4 placed 30 ml into a large syringe (a 60 ml syringe that enables tube feeding and water flushes) and attached the syringe to Resident 4's [DEVICE] port. LVN 4 raised the [DEVICE] and syringe to allow water to flow in by gravity, but the water did not enter the [DEVICE]. LVN 4 then began squeezing the entire [DEVICE] connected to the resident. LVN 4 stated, The tubing felt squishy and was milking it (squeezing the tubing) to unclog it. LVN 4 continued to squeeze the entire tubing and pull at tubing while doing so. An abdominal binder (an elastic abdominal support band) was over the entry point of [DEVICE]. LVN 4 pulled and squeezed the [DEVICE] with enough force to cause the binder to lift away from Resident 4's abdomen. On 2/6/20 at 5:55 a.m., during an observation and interview, LVN 4 stated he needed to grab a declogger located in the facility's supply room. LVN 4 went to the facility's supply room, where he grabbed two long declogger packages. At 6 a.m., LVN 4 entered Resident's 4 room and applied gloves without performing hand hygiene. LVN 4 opened the declogger package, removed the declogger device, and discarded the packaging in the trash can. LVN 4 did not read the packaging instructions and began inserting the declogger, a long light blue flexible plastic stick, approximately 16 inches long, into Resident 4's [DEVICE]. After fully inserting the declogger into the [DEVICE], LVN 4 began twisting the declogging device in a right and left twisting motion while squeezing and milking the [DEVICE]. During an observation and interview, on 2/6/20 at 6:09 a.m., LVN 4 stated he needed to use another declogger and tried again. LVN 4 again opened the declogger packaging, removed the declogger and discarded the packaging, with the instructions into the trash can. LVN 4 then reinserted the declogger into Resident 4's [DEVICE] using the same twisting motion while squeezing and milking the [DEVICE]. At 6:20 a.m. LVN 4 removed the declogger, threw it away in the trash can. LVN 4 proceeded to the restroom and obtained warm water from the sink. LVN 4 then placed 30 ml of water into a syringe and attached it to Resident 4's [DEVICE]. LVN 4 began forcefully pushing on the plunger trying to inject water into [DEVICE] multiple times. At 6:25 a.m., after two unsuccessful attempts with the declogger's and three unsuccessful attempts with the warm water, LVN 4 stated he would go to doctor's room and ask the physician's assistant (PA) what he should do. LVN 4 returned and stated the PA told him to get another nurse to try. During an interview, on 2/6/20 at 7:00 a.m., LVN 4 stated he had pre documented Resident 4's [DEVICE] feeding change at 4 a.m. instead of the actual time of 6:44 a.m. LVN 4 stated documentation should be done in real time in case something happens. LVN 4 also stated the feeding was infusing at a lower rate than ordered by the physician. Resident 4 did not receive feeding for 1.5 hours while he tried to unclog the [DEVICE]. LVN 4 stated this could lead to Resident 4 being malnourished. LVN 4 added he did not document declogging the [DEVICE] because there was no place to do so. LVN 4 stated he never received any training on declogging the [DEVICE] and this was his first time using the declogger. LVN 4 stated he saw the declogging device in the supply room, so he thought he would use it. LVN 4 stated he did not know the policy on declogging and did not know where any of the facility's policies were located. LVN 4 stated it was important to have access to policies so he would know how to do his job and provide the best care. LVN 4 stated the facility never trained him to check for residual in the [DEVICE] and he just thought he needed to inject air to check for [DEVICE] placement. LVN 4 continued that he was not sure how to unclog a [DEVICE] so he guessed he could squeeze and pull on the [DEVICE] in an up and down motion. LVN 4 stated pulling on the [DEVICE] could cause displacement or dislodgement (removal). LVN 4 stated by forcing water into the [DEVICE] with the syringe could have burst or rip the [DEVICE]. During an interview on 2/6/20 at 1:11 pm, LVN 6 stated she was never trained to use the declogger. LVN 6 stated she observed a licensed nurse use a declogger on a resident during her orientation. LVN 6 stated she did not know how to use it a declogger and was unsure if there was a policy for a declogger. A review of Resident 4's Progress Notes dated 2/6/20 indicated LVN 4 did not document trying to unclog the [DEVICE] with the declogging device nor consultation the physician's assistant (PA). During a concurrent interview and observation, on 2/6/20 at 1:11 p.m., LVN 6 entered the supply room, a box of 10 declogger's were packaged in a box on the shelf. There were six declogger's remaining in the box. LVN 6 stated she was never trained on how to use the declogger devices. LVN 6 stated she observed the declogger being used once during her orientation by another nurse. LVN 6 stated she did not know if there was a policy for the declogger's and did not know how to use the declogging device. During a concurrent observation and interview on 2/7/20 at 12:54 pm, treatment nurse 1 (TX 1) stated she was not sure what Resident 4's external graduation marks on the [DEVICE] indicated. TX 1 stated she was not taught how and the importance of measuring the length of G tubes. TX 1 stated she did not know about the policy on [DEVICE]s or where policies are located. TX 1 stated she was responsible for changing residents' [DEVICE] dressings. During an interview on 2/6/20, at 1:38 pm, the Director of Staff Development (DSD) stated the declogger was occasionally used by licensed staff and should have a physician's orders [REDACTED]. The DSD stated could cause a tear a declogger could get stuck inside a [DEVICE]. The DSD stated she was never trained on how to use the declogger and that she provided in-services on the declogger based off the packaging instructions. During an interview on 2/6/20 at 2:20 pm, with the DON, stated when administered medications to a resident with a G tube, 5-10 ml of water should be flushed on between each medication. The DON stated if flushing is not done in between medications, the medication would not completely dissolve or be administered and could also increase the risk for clogging the G tube. A review of Resident 4's progress notes, dated 2/6/20 at 4:08 p.m., indicated LVN 4 used a declogger on Resident 4's [DEVICE] at approximately 6 a.m. The progress notes indicated the licensed nurse did not obtain a physician's orders [REDACTED]. The progress notes also indicated the licensed nurses are not professionally trained in the use of the declogging device. During an interview on 2/7/20 at 1:15 pm, the DON stated the use of a declogger could cause nausea and vomiting, cramping, pain, or cause trauma to the lining in the stomach. The DON stated the facility has used the declogger's since before April of 2018. The DON stated I am not going to beat around the bush, no physicians order, we identified deficient practice yesterday. The DON stated she could not locate a policy for the declogger. A review of the facility's policy, titled, Gastrostomy Tube, revised on May 2019, indicated, to flush the tube with 5-10 ml of water after administering each medication. The policy indicated if a tube becomes clogged, Never insert a devise into a gastrostomy tube. The American Society for [MEDICATION NAME] and Enteral Nutrition (ASPEN) recommends warm water as the best initial choice for trying to unclog a feeding tube. Additional second-line interventions include using a commercially available enzyme declogging kit or mechanical declogging device. These also must be used in accordance with facility policy and procedure and only by experienced clinicians . Nursing2019: June 2018 - Volume 48 - Issue 6 - p 66 doi: 10.1097/01.NURSEXXX XXX .5e c. A review of Resident 6's Face Sheet indicated an admission to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident 6's H&P, dated [DATE]8/19, indicated the resident did not have the capacity to understand or make decisions, A review of Resident 6's MDS dated [DATE], indicated the resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. During a medication

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	056360	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR GLEN CARE CENTER	**1033 E. ARROW HIGHWAY GLENDORA, CA 91740**

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) administration observation on 2/6/20, at 9 am, LVN 1 paused Resident 6's continuous [DEVICE] feeding. LVN 1 did not check the resident's [DEVICE], site or surrounding. LVN 1 used a syringe to flush the resident's [DEVICE] with 40 ml of water. LVN 1 administered the following medications through the resident's [DEVICE]: Aspirin 81 milligrams (mg) 1 tablet (tab) [MEDICATION NAME] 50 mg 1 tab [MEDICATION NAME] 20 mg 1 tab [MEDICATION NAME] ([MED]) 1,000 mg 1 tab [MED] [MED] 5 mg [MEDICATION NAME] 15 ml Multivitamins with mineral 1 tab [MEDICATION NAME] 10 ml [MEDICATION NAME] 45 ml LVN 1 did not flush the [DEVICE] with water in between each medication. LVN 1 then flushed the resident's G- tube with 40 ml of water and immediately resumed Resident 6's continuous feeding of Glucerna 1.2 cal at 70 ml/hr. During an interview on 2/6/20, at 9:30 am, LVN 1 stated she did not perform a flush of water between each medication administered for Resident 6. LVN 1 stated that a flush was not necessary and only done prior to medication administration and after the last medication is administered. LVN 1 stated she monitors the resident's discomfort, the [DEVICE] residual and or any drainage from the [DEVICE] site. During an interview on 2/6/20, at 12:41 pm, the DON stated that she and the DSD were responsible to ensure licensed staff were competent in caring for residents with [DEVICE]s. A review of Resident 6's Laboratory Result Report indicated on: 7/5/19, [MEDICATION NAME] ([MEDICATION NAME]) level of 6.0 micrograms per milliliter (mcg/ml, reference range 10-12 mcg/ml) 7/8/19 was 4 mcg/ml on 7/8/19. A review of Resident 6's Progress Note indicated that on: 7/5/19, [MEDICATION NAME] dose was changed from 8 ml every twelve hours to 1 every twelve hours, and to recheck [MEDICATION NAME] levels on 7/8/19. 7/8/19, [MEDICATION NAME] dose was increased from 1 every twelve hours to 15 ml two times a day, and to repeat [MEDICATION NAME] labs on 7/12/19. 7/12/19, indicated Resident 6 refused blood draw for [MEDICATION NAME] levels. A review of Competency Check List for caring for a nasogastric/gastric tube (NG/GT), assessment, placement, position of resident while feeding, and medication administration indicated the DON signed off that LVN 1 and 4 were competent. During an interview on 2/6/20, at 2:07 pm, LVN 1 stated the importance of flushing medications administered via G tube was done to ensure the full dosage of the medication was administering. LVN 1 stated that no training on flushing in between medications was taught by the facility to LVN 1. LVN 1 stated that physician's orders [REDACTED]. LVN 1 stated when giving [MEDICATION NAME] suspension to Resident 6, there was no special instructions provided prior to the administration of [MEDICATION NAME]. On a concurrent record review of Resident 6's Medication Administration Record [REDACTED]. LVN 1 stated, I messed up. During an interview on 2/6/20 at 2:20 pm, with the DON, stated when administered medications to a resident with a G tube, 5-10 ml of water should be flushed on between each medication. The DON stated if flushing is not done in between medications, the medication would not completely dissolve or be administered and could also increase the risk for clogging the G tube. A review of the facility's Director of Nurses (DON) Job Description dated [DATE]6/18, indicated the nursing care functions for the DON included reviewing nurse's notes to ensure they were informative and descriptive. The job description also indicated care plan and assessment functions included; development of written plan of care for each resident, ensuring all personnel involved in providing care to the resident were aware of the resident's care plan, reviewing nurse's notes to ensure care plan were being flowed, and reviewing and revising care plans as necessary. A review of the facility's policy titled Gastrostomy - site care revised on 5/2007, indicated date and time of care, condition of stoma site and surrounding skin, centimeters marking of skin disc French size of tube, and resident's tolerance of procedure needed to be documented. A review of the facility's policy titled Licensed Nurse Procedures: Enteral Tube - Patency Check revised on 5/2007, indicated it was the policy of that facility to ascertain that the feeding tube was both in proper place and patent (intact). The policy indicated patency checks needed to be done and documented every eight hours in the progress notes. A review of the facility's policy titled Gastrostomy tube revised on 5/2019, indicated it was the policy of the facility to provide proper care and maintenance of a G tube. The policy indicated there was a daily checklist for G tubes, which included checking for pain, checking the tube exit site, rotating the tube and external bolster turn, daily cleaning of stoma sites, verifying position before every feeding, and flushing the feeding tube and adapter every four hours per physician's orders [REDACTED].
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 administer medications as ordered by the physician and follow proper gastrostomy tube ([DEVICE], a tube inserted through the abdomen directly into the stomach for nutrition, hydration and medication) medication administration policy. This deficient practice had the potential to increase or delay the absorption of the medications administered. Findings: On 2/6/20 at 5:08 am, an onsite visit was conducted at the facility to investigate a complaint. During a medication administration observation on 2/6/20 at 8:28 am with Licensed Vocational Nurse 1 (LVN 1), was observed preparing Resident 6's medications. LVN 1 stated that [MEDICATION NAME] (medication to control abnormal blood sugar) was late. LVN 1 prepared the following medications to be administered [DEVICE] in individual medicine cups: Aspirin (medication to prevent blood clots) 81 milligrams (mg, measuring unit) 1 tablet (tab) Multivitamin (supplement)1 tab [MEDICATION NAME] ([MED]) 1,000 mg, [MEDICATION NAME] (medication to treat abnormal blood pressure) 20 mg 1 tab [MED] (medication used to treat moderate-to-severe [MEDICAL CONDITION] (that causes problems with memory, thinking and behavior)) [MED] 5 mg 1 tab [MEDICATION NAME] (medication to treat abnormal blood pressure) 500mg 1 tab [MEDICATION NAME] (medication to treat/prevent [MEDICAL CONDITION]) suspension 15 ml [MEDICATION NAME] (medication to treat/prevent [MEDICAL CONDITION])10 ml [MEDICATION NAME] (to control ammonia (a waste product made by the body during the digestion of protein) levels) 45 ml. 45 ml. LVN 1 checked Resident 6's [DEVICE] for placement and residual. However, LVN 1 did not flush the resident's [DEVICE] in between administering each medication. LVN 1 then flushed the resident's [DEVICE] flushed the resident's [DEVICE] with 40 ml of water and immediately resumed the [DEVICE] feeding at 70 ml/hr after administering all medications. During an interview on 2/6/20 at 9:20 am, LVN 1 stated that no flush was done in between medications and that the continuous feeding for Resident 1 was paused prior to beginning Resident 6's medication administration. A review of Resident 6's Face Sheet, indicated the facility admitted the resident on 5/[DATE]7 with [DIAGNOSES REDACTED]. A review of Resident 6's History and Physical (H&P), dated [DATE]8/19, indicated the resident did not have the capacity to understand or make decisions, A review of Resident 6's Minimum Data Set (MDS, a standardized care-screening and assessment tool), dated [DATE], indicated Resident 6 had no capacity to understand and make decisions, and required extensive assistance with bed mobility, dressing, toilet use and personal hygiene During an interview on 2/6/2020, at 2:07 pm, LVN 1 stated she did not flush the [DEVICE] with water in between administering medications for Resident 6. LVN 1 stated it was important to flush the resident's [DEVICE] with water in between administering medications to ensure the full dosage of the medication was administered. LVN 1 stated she the facility did not in-service her to the flush [DEVICE] in between administering medications. On a concurrent record review with LVN 1, the facility's policy titled Gastrostomy Tube revised on 5/2019, indicated to flush the tube with 5-10 ml of water after administering each medication. During an interview on 2/6/2020 at 2:20 pm, with the Director of Nurses (DON), stated [DEVICE] should be flushed with 5-10 ml of water in between each medication to ensure the medication completely dissolves, the full dose is/are administered and prevent clogging of the [DEVICE]. A review of the facility's policy, titled, Gastrostomy Tube, with a revision date of May 2019, indicated, to flush the tube with 5-10 ml of water after administering each medication.

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 a medication error rate of 5 percent (%) or less, for four of four sampled residents (Residents 4, 5, 6 and 7) during medication administration observations as evidenced by: 1. Failing to administer 5-10 milliliter (ml, measuring unit) of water (flush) in between each medication via gastrostomy tube ([DEVICE], a device inserted into the stomach through the abdomen for hydration, nutrition and medication) for Resident 6. 2. Administering [MEDICATION NAME] [MED] (medicine that helps control abnormal blood sugar levels) late for Resident 6. 3. Crushing and mixing [MEDICATION NAME] (medicine that helps prevent stroke) and [MEDICATION NAME] [MED] together in one medication cup for Resident 5. 4. Failing to use a dosing card to measure [MEDICATION NAME] Sodium 1% ([MEDICATION NAME], a medication to treat joint pain) [MEDICATION NAME] (through the skin) gel for Resident 7. 5. Failing to sign Medication Administration Record [REDACTED]. Findings: a. A review of Resident 6's Face Sheet, indicated the facility admitted the resident on 5/[DATE]7 with [DIAGNOSES REDACTED]. A review of Resident 6's History and Physical (H&P), dated [DATE]8/19, indicated the resident did not have the capacity to understand or make decisions, A review of Resident 6's Minimum Data Set (MDS, a care-screening and assessment tool), dated [DATE], indicated the resident had no

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	056360	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR GLEN CARE CENTER	**1033 E. ARROW HIGHWAY GLENDORA, CA 91740**

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 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) capacity to understand and make decisions, and required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. During [DEVICE] medication administration observation on 2/6/2020 at 8:28 am., Licensed Vocational Nurse 1 (LVN 1) prepared, and or crushed, and administered the following medications for Resident 6: Aspirin 81 milligrams (mg, measuring unit) 1 tablet (tab) Multivitamins (Vitamins supplement) 1 tab [MEDICATION NAME] ([MED], oral diabetes medication) 1,000 mg 1 tab scheduled to be administered at 7:00 am. [MEDICATION NAME] (to manage/treat abnormal blood pressure) 20 mg 1 tab [MED] [MED] (treats symptoms of [CONDITION] (irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks)) 5 mg 1 tab [MEDICATION NAME] 50 mg (medication to treat abnormal blood pressure) 1 tab Iron (medication to treat [MEDICAL CONDITION]) 7 milliliter (ml, measuring unit) [MEDICATION NAME] (to control [MEDICAL CONDITION]) 10 ml [MEDICATION NAME] (to control ammonia (is a waste product made by the body during the digestion of protein) levels) 45 ml. However, LVN 1 did not flush the [DEVICE] with 5-10 ml of water in between each medication. Concurrently, LVN 1 stated that [MEDICATION NAME] was already late. On a concurrent review of Resident 6's Medication Administration Record [REDACTED]. During an interview on 2/6/2020, at 2:07 pm, LVN 1 stated she did not flush the [DEVICE] with water in between administering medications for Resident 6. LVN 1 stated it was important to flush the resident's [DEVICE] with water in between administering medications to ensure the full dosage of the medication was administered. LVN 1 stated she the facility did not in-service her to the flush [DEVICE] in between administering medications. On a concurrent record review with LVN 1, the facility's policy titled Gastrostomy Tube revised on 5/2019, indicated to flush the tube with 5-10 ml of water after administering each medication. During an interview on 2/6/2020 at 2:20 pm, with the Director of Nurses (DON), stated [DEVICE] should be flushed with 5-10 ml of water in between each medication to ensure the medication completely dissolves, the full dose is/are administered and prevent clogging of the [DEVICE]. A review of the facility's policy, titled, Gastrostomy Tube, with a revision date of February 6, 2020, indicated: 1. Never mix medications. Mixing medications can cause them to interact in a way that will result in a clogged tube. 2. Administer all medications individually. 3. Flush the tube again with 5-10 cc of water after administering each medication. b. A review of Resident 5's Face Sheet indicated the facility admitted the resident on 4/[DATE]7, with [DIAGNOSES REDACTED]. A review of Resident 5's history and physical examination [REDACTED]. A review of Resident 5's MDS dated [DATE], indicated the resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. During medication administration observation on 2/6/2020 at 8:01 am, LVN 2 prepared the following medications to be administered through the [DEVICE] for Resident 5: [MEDICATION NAME] 75 mg 1 tab [MEDICATION NAME] Sodium (Dicoto, stool softener) 10 ml [MEDICATION NAME] (to treat abnormal blood pressure) 12.5 mg 1 tab [MEDICATION NAME] [MED] 500 mg 1 tab LVN 2 poured [MEDICATION NAME] Sodium 10 ml, and [MEDICATION NAME] in two separate medicine cups. LVN 2 crushed [MEDICATION NAME] and [MEDICATION NAME] separately, then poured and mixed both medications in one medicine cup and administered to the Resident 5 via the [DEVICE]. During an interview on 2/6/2020 at 8:35 am, LVN 2 stated medications should crushed separately and placed in individual medicine cups to prevent drug interaction. A review of the facility's policy, titled, Gastrostomy Tube, with a revision date of February 6, 2020, indicated: 1. Never mix medications. Mixing medications can cause them to interact in a way that will result in a clogged tube. 2. Administer all medications individually. c. A review of Resident 7's Face Sheet, indicated the facility admitted the resident on 2/26/19 with [DIAGNOSES REDACTED]. A review of Resident 7's H&P, dated 12/18/19, indicated the resident has the capacity to understand and make decisions. A review of Resident 7's MDS dated [DATE], indicated the resident required limited assistance with bed mobility, dressing, toilet use and personal hygiene. During medication administration observation on 2/6/2020 at 9:04 am, LVN 2 prepared and administered the following medications for Resident 7: [MEDICATION NAME] 1 mg (treat [MEDICAL CONDITION] or for history of [MEDICAL CONDITION]) 1 tab Artificial Tears Solution 0.4% (moisten eyes) [MEDICATION NAME] acid 500 mg (Vitamin C- supplement involved in the repair of tissue) 1 tab [MEDICATION NAME] 100 mg (treat abnormal blood pressure) 1 tab [MEDICATION NAME] 40 mg (treat fluid buildup, swelling) 1 tab [MEDICATION NAME] 5 mg (treat abnormal blood pressure and fluid buildup) 1 tab [MEDICATION NAME] 5 mg (treat abnormal blood pressure and chest pain) 1 tab Potassium Chloride ER extended release (treat abnormal levels of potassium in blood) 1 tab. Concurrently, Resident 7 then complained of pain on the left wrist. LVN 2 stated she forgot to prepare and apply [MEDICATION NAME] gel 1% on the resident. Concurrently, LVN 2 squeezed approximately 5 cubic centimeters (cc- measurement of volume) of [MEDICATION NAME] gel 1% in a medicine cup and applied the gel on both wrists of Resident 7. A review of Resident 7's Order Summary dated 2/1/2020, indicated the resident has an order for [REDACTED]. On a concurrent interview, LVN 2 stated the resident has an order to administer [MEDICATION NAME] gel 1% 4 gm. LVN 2 stated should have used the dosing card to measure the correct medication dose and prevent the risk of over or under dosing Resident 7. A review of the facility's policy titled Medication Administration, revised on 10/2019, indicated the 6 rights included the right time and right dose. The policy indicated, a medication error would occur if any of the 6 rights has been violated. A review of [MEDICATION NAME] gel 1% package indicated, Use the dosing card inside the package. In an interview on 2/6/20, at 9:35 a.m., LVN 2 stated [MEDICATION NAME] gel 1% 4 G should have been measured by using the dosing card inside the medication package because of the risk of either overdosing or under dosing the resident with the medication. A review of the nurse's progress note dated 2/6/20, at 11:01 am, the note indicated, Charge nurse administered [MEDICATION NAME] 1% 4 G without the supplied applicator on Resident 7. A review of the facility's policy, titled, Gastrostomy Tube, with a revision date of February 6, 2020, indicated, Never mix medications. Mixing medications can cause them to interact in a way that will result in a clogged tube. Administer all c. A review of Resident 5's Face Sheet indicated the facility admitted the resident on 4/[DATE]7, with [DIAGNOSES REDACTED]. A review of Resident 5's history and physical examination [REDACTED]. A review of Resident 5's MDS dated [DATE], indicated the resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. During an observation of medication administration on 2/6/20 at 8:01 a.m., Licensed Vocational Nurse 2 (LVN 2) prepared and administered the following medications for Resident 5: [MEDICATION NAME] (prevent stroke) 75 milligrams (mg) 1 tablet (tab) [MEDICATION NAME] Sodium (Dicoto, stool softener) liquid 10 milliliter (ml) [MEDICATION NAME] (medication to treat abnormal BP)12.5 mg 1 tab [MEDICATION NAME] [MED] (controls blood sugar levels) 500 mg 1 tab. During an interview on 2/6/20 at 8:30 a.m., and did not chart immediately after completing the medication pass. LVN 2 stated medication administration should be documented in real time for accurate documentation. A review of the facility's policy, titled, Med Pass, with a revision date of October 2019, indicated, Pour-pass-chart- correctly prepare the med, give it correctly, then chart your action, sign that med was given on the med sheet after resident takes med, and before going to the next resident.

F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that Glucerna (nutritional supplement) infused continuously via gastrostomy tube ([DEVICE], device that's inserted into the stomach through the abdomen), was on hold for one hour prior to administering [MEDICATION NAME] (anticonvulsant medication) for one of three residents (Resident 6). This deficient practice resulted in a significant medication error, and had the potential to delay the absorption of [MEDICATION NAME] for Resident 6. Findings: On 2/6/20 at 5:08 am, an onsite visit was conducted at the facility to investigate a complaint. A review of Resident 6's Face Sheet, indicated the facility admitted the resident on 5/[DATE]7 with [DIAGNOSES REDACTED]. A review of Resident 6's History and Physical (H&P), dated [DATE]8/19, indicated Resident 6 did not have the capacity to understand or make decisions, A review of Resident 6's Minimum Data Set (MDS, a standardized care-screening and assessment tool), dated [DATE], indicated the resident had no capacity to understand and make decisions, and required extensive assistance with bed mobility, dressing, toilet use and personal hygiene During a medication administration observation on 2/6/20 at 8:28 am with Licensed Vocational Nurse 1 (LVN 1), paused Resident 6's [DEVICE] feeding and administered 15 ml of [MEDICATION NAME] suspension via the resident's [DEVICE]. LVN 1 immediately resumed the resident's [DEVICE] feeding of Glucerna 1.2 cal at 70 milliliter per hour (ml/hr) via the [DEVICE]. During an interview on 2/6/20, at 2:07 pm, LVN 1 stated that there was no special instructions on how to administer [MEDICATION NAME] suspension for Resident 6. On a concurrent record review, Resident 6's Medication Administration Record [REDACTED]. LVN 1 could not state the importance of holding [DEVICE] feeding for an hour before administering [MEDICATION NAME]. LVN 1 stated, I messed up. During an interview on 2/6/20, at 2:20 pm, the Director of Nurses (DON) stated [MEDICATION NAME] is a medication for [MEDICAL CONDITION] (anticonvulsant) and the [DEVICE] feeding should be stopped for an one hour prior to administration and promote the medication absorption. The DON stated there was an increased risk for [MEDICAL CONDITION] due to not holding

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) the [DEVICE] feeding as directed. A review of the facility's policy, titled Medication Administration, with a revision date of October 2019, indicated a med error can occur if any of the 6 rights has been violated, or if regulations, approved house, or current standards of practice have been violated. The policy also indicated a significant error is one that has the potential for causing harm to the resident.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to observe infection control measures by failing to: 1. Hand hygiene was performed prior to entering Resident 5's room for medication administration. 2. Disinfect a shared blood pressure cuff (device used to measure blood pressure) prior to storing it back in the medication cart after use. These deficient practices resulted in contamination of the resident's care equipment and placed the residents at risk for infection. Findings: During a medication administration observation on 2/6/20, at 8:01 a.m., Licensed Vocational Nurse 2 (LVN 2) entered Resident 5's room, checked the resident's name band, recorded the resident's blood pressure (BP) and paused hold on the resident's feeding pump (medical device to deliver enteral (involving or passing through the intestine) feed to residents with [DEVICE]s) without performing hand hygiene. LVN 2 placed the BP cuff on top of the medication cart without sanitizing. LVN 2 then performed hand hygiene. A review of Resident 5's Face Sheet indicated the facility admitted the resident on 4/[DATE]7, with [DIAGNOSES REDACTED]. A review of Resident 5's history and physical examination [REDACTED]. A review of Resident 5's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 10/1/19, indicated the resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. During an interview on 2/6/20 at 8:36 a.m., LVN 2 stated, hand hygiene must be performed during resident care to prevent the spread of germs. LVN 2 stated, the blood pressure cuff was not cleaned. LVN 2 stated the blood pressure cuff needs to be sanitized with a sanitizing wipe before placing it back into the medication cart for infection control. A review of the facility's policy titled Hand Washing revised on May 2019, indicated it was the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. The policy also indicated that some situations require hand washing in areas where sinks are not readily available. In these limited circumstances, waterless hand washing products may be used (e.g. feeding residents in the dining room, administering medications in the dining room). These products are not a substitute for good hand washing. Hand washing with soap and water should be done as soon as possible. A review of the facility's policy titled Gastrostomy Tube revised on May 2019, indicated Wash your hands before handling gastrostomy tubes and attachments to decrease the risk of infection. A review of the facility's policy titled Infection Control Program revised on May 2007, indicated Staff and patient education is done to focus on risk of infection and practices to decrease risk. Policies, procedures and aseptic practice are followed by personnel in performing procedures and in disinfection of equipment. A review of the facility's policy titled Hand Washing with a revision date of May 2019, indicated it was the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. The policy also indicated that some situations require hand washing in areas where sinks are not readily available. In these limited circumstances, waterless hand washing products may be used (e.g. feeding residents in the dining room, administering medications in the dining room). These products are not a substitute for good hand washing. Hand washing with soap and water should be done as soon as possible.