STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	831 S LAKE STREET LOS ANGELES, CA 90057

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician obtained informed consent for one of five sampled residents (Resident 26) prior to initiating a hypnotic drug (a type of [MEDICAL CONDITION] (medications that affect mental function, behavior, and experience) drug used to help with sleep) and failed to ensure licensed vocational nurses (LVNs) verified an informed consent was obtained before administering [MEDICAL CONDITION] medications. This deficient practice placed Resident 26 at risk of not being well informed of the risks and benefits of taking a hypnotic drug. Findings: A review of Resident 26's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. by a terrifying event). A review of Resident 26's history and physical examination [REDACTED]. A review of Resident 26's physician's orders [REDACTED]. A review of Resident 26's Medication Administration Record [REDACTED]. During a concurrent interview and record review with LVN 5 on [DATE] at 10:27 a.m., LVN 5 confirmed the facility's policy indicated physicians must obtain an informed consent prior to administering a [MEDICAL CONDITION] drug like [MEDICATION NAME]. LVN 5 confirmed Resident 26's physician did not obtain an informed consent for the new order of [MEDICATION NAME] dated 3/6/20. LVN 5 also confirmed licensed nurses did not verify the physician obtained a new informed consent for the use of [MEDICATION NAME] prior to administering the medication. LVN 5 stated as a result, Resident 26 and/or Resident 26's responsible party were not fully aware of the medications being given to him. A review of the facility's undated policy titled Informed Consent indicated it is the physician's responsibility to obtain the informed consent from the resident and the facility licensed staff verifies that informed consent has been obtained before the orders are carried out by the nursing staff.
F 0577 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation, interview, and record review, the facility failed to display the most recent recertification survey (conducted by State and Federal surveyors to ensure compliance with Medicare health and safety regulations) results in a visible and accessible area and failed to post any signs indicating survey results were available to read. This deficient practice denied residents, family members, and visitors the right to read about the facility's deficiencies (violation of a regulation) and intended plan of correction (how the facility plans to correct the deficiency) and did not allow residents, family members, and visitors the opportunity to make more informed decisions regarding their choice of residence. Findings: During a Resident Council (an organized group of nursing home residents that meet on a regular basis to discuss concerns, suggest changes the residents would like, and identify and plan for desired social activities) meeting on 3/3/20 at 10:04 a.m., three out of three residents who attended the meeting stated they were unaware that the results of the most recent survey were available to read and did not remember seeing any signs notifying them of the availability of such results. During a tour of the facility on 3/4/20 at 9:39 a.m., the most recent survey results were not observed in areas that were accessible and visible to the public. During an interview with the facility's receptionist on 3/4/20 at 9:50 a.m., the receptionist stated the bin containing the most recent survey results fell off the wall recently, and they had not yet fixed the bin. The receptionist could not locate the most recent survey results when asked where they were. Approximately ten minutes later, the receptionist stated she found the survey results in a binder that was located inside the Director of Nursing's (DON) closed office. When asked if there were any signs indicating survey results were available to read, the receptionist could not locate any visible signs posted on the wall. The receptionist confirmed it was difficult for residents, family members, and visitors to access the binder if the binder was located inside the DON's office and if there were no signs indicating the availability of such results. During an interview with the Director of Nursing (DON) on [DATE] at 4:59 p.m., the DON confirmed the most recent survey results should have been accessible at all times and stated it was important for residents, family members, and visitors to have access to the most recent survey results so that they could make informed decisions about their choice of residence. A review of the policy titled Survey Results, Examination of revised 4/2007 indicated a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisit reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed provide residents with written information describing what an advance directive is and how to formulate one for five of eight sampled residents (Resident 26, 58, 65, 83, and 93). This deficient practice led to lack of education regarding an advance directive and did not provide residents with the opportunity to make future decisions about their own critical care in the event they are unable to decide for themselves. Findings: A. A review of Resident 26's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to an infection), and [MEDICAL CONDITION] (a long-term lung condition that makes it hard to breathe). A review of Resident 26's history and physical examination [REDACTED]. A review of Resident 26's advance directive acknowledgement form (a form given to residents indicating they were informed of their right to formulate advance directives, given written materials regarding advance directives, and specified whether or not they desired to create an advance directive if they did not already have one) dated 2/25/20 indicated the resident was given written materials and informed about the right to accept or refuse medical treatments and informed of rights to formulate an advance directive. B. A review of Resident 58's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 58's history and physical examination [REDACTED]. A review of Resident 58's advance directive acknowledgement form dated 2/20/20 indicated the resident was given written materials and informed about the right to accept or refuse medical treatments and informed of rights to formulate an advance directive. C. A review of Resident 65's admission record indicated the resident

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED].)),[MEDICAL CONDITION] (a potentially life-threatening condition caused by the body's response to an infection), and chronic [MEDICAL CONDITIONS] (a serious liver infection caused by [MEDICAL CONDITION]). A review of Resident 65's history and physical examination [REDACTED]. A review of Resident 65's advance directive acknowledgement form dated 2/11/20 indicated the resident was given written materials and informed about the right to accept or refuse medical treatments and informed of rights to formulate an advance directive. D. A review of Resident 83's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to an infection), and heart failure (when the heart is unable to pump blood as well as it should) A review of Resident 83's history and physical examination [REDACTED]. A review of Resident 83's advance directive acknowledgement form dated 1/24/20 indicated the resident was given written materials and informed about the right to accept or refuse medical treatments and informed of rights to formulate an advance directive. E. A review of Resident 93's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 93's history and physical examination [REDACTED]. A review of Resident 93's advance directive acknowledgement form dated 11/21/19 indicated the resident was given written materials and informed about the right to accept or refuse medical treatments and informed of rights to formulate an advance directive. During an interview with the customer service representative (CSR) on 3/5/20 at 9:17 a.m., the CSR stated she helps residents complete the advance directive acknowledgment form upon admission to the facility. When asked what information she provides to the residents regarding advance directives, the CSR stated she does not provide any pamphlet or written material describing what an advance directive is and how to formulate one. The CSR stated she thought advance directives were the same as Physician order [REDACTED]. During an interview and concurrent record review with the Social Services Designee (SSD) on 3/5/20 at 1:55 p.m., the SSD confirmed the advance directive acknowledgement forms signed by the aforementioned residents did not accurately reflect the residents' understanding of what an advance directive was since the CSR was unaware herself. The SSD also confirmed information concerning advance directives should be available in the residents' respective languages and be presented in a manner that is well understood by residents. The SSD stated advance directives were important because a resident was able to legally appoint someone who could make decisions for them in the event they are incapacitated (unable to decide for themselves due to illness or injury). A review of the facility's policy titled Advance Directives revised 4/2013 indicated prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** Based on interview and record review, the facility failed to keep medical information private for one of one sample residents (Resident 4) when a licensed nursing staff posted the residents medical information on a social media platform. This deficient practice left Resident 4's private medical information available to the public, the healthcare data was not safeguarded and the privacy of the resident was not protected. Findings: During an interview with Licensed Vocational Nurse 5 (LVN 5) on 3/09/20 3:54 p.m., LVN 5 stated that he had posted Resident 4's medical information on his social media account. LVN 5 stated he had 200 followers on his social media account and that the medical information he had posted received 100 views. LVN 5 confirmed that posting Resident 4's medical information on his social media account is a violation of the Health Insurance Portability and Accountability Act (HIPAA- data privacy and security provisions for safeguarding medical information). LVN 5 stated he should have not posted the residents medical information. LVN 5 stated the Director of Staff Development (DSD) reviewed HIPAA information when he was initially hired. During a record review on [DATE] at 3:00 p.m. with the Administrator (ADM), ADM presented LVN 5's Employee Notice of Discipline (action taken against staff as a result of violating policy and procedure) dated [DATE]. The document indicated the disciplinary action was a final warning and the corrective actions to be taken was termination if a similar incident happens again. A review of LVN 5's Employee Acknowledgement dated 11/30/19, indicated LVN 5 had received the facility policy titled, Social Networking Policy Acknowledgement. During a reviewed of the facility's policy and procedure titled Social Networking Policy Acknowledgement, dated 1/22/20, indicated in the event that staff participates in personal blogging (the practice of posting information, views, etc. on the Internet) they do not disclose confidential information. The document indicated failure to comply with this policy will result in corrective or disciplinary action up to and including termination.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure four of 20 sample residents' (Residents 7, 45, 51, and 61) were free from neglect, which included, but were not limited to: 1. Failure to administer 414 doses of [MEDICATION NAME] (a medication used to treat Human Immunodeficiency Virus (HIV - [MEDICAL CONDITION] that causes a weakened immune system)) 100 milligrams ((mg) - a unit of measure for mass) to one of 20 observed residents (Resident 61) between [DATE] and [DATE]. 2. Failure to administer 176 doses of [MED] (an inhaled medication used to treat breathing problems) to one of 20 observed residents (Resident 45) between [DATE] and [DATE]. 3. Failure to administer 60 doses of [MEDICATION NAME] (a medication used to treat high blood sugar) to one of 20 observed residents (Resident 7) between [DATE] and [DATE]. 4. Failure to administer five doses of Potassium Chloride ER (a medication used to supplement low potassium levels) eight milliequivalents ((mEq) - a measure of strength for medications like potassium) to one of 20 observed residents (Resident 51) between [DATE] and [DATE]. The deficient practice of failing to administer medications in accordance with physician's orders [REDACTED]. Cross-reference F684 and F760. On [DATE] at 3:30 p.m., the Department of Public Health (Department) called an Immediate Jeopardy situation (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 (ADM) and director of nursing (DON). On [DATE] at 11:41 a.m., while onsite and after confirming the facility's implementation of the immediate corrective actions, the Department accepted the Plan of Action (POA) and removed the Immediate Jeopardy, in the presence of the ADM and the DON. Findings: A. A review of Resident 61's admission record, dated [DATE], indicated that she was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. [REDACTED]. A review of Resident 61's MAR between [DATE] and [DATE] indicated that a total of 654 doses of [MEDICATION NAME] 100 mg were signed as administered to Resident 61 and a total of 10 doses were documented as refused or omitted. On [DATE] at 10:05 a.m., during an interview, the medical records director (MRD) stated that he could not find any record of pharmacy delivery history for Resident 61's [MEDICATION NAME] but knows that the resident uses two different pharmacies to deliver [MEDICAL CONDITION] (Pharmacy 1 and Pharmacy 2.) On [DATE] at 10:51 a.m., during a telephone interview, the pharmacy technician (PTC 3) stated that Pharmacy 1 only had records of delivering a 15-day supply of [MEDICATION NAME] (the generic name for [MEDICATION NAME]) 100 mg for Resident 61 on [DATE]. PTC 3 stated that another order was placed on [DATE] but was not delivered due to insurance reasons. PTC 3 stated that the most recent delivery from Pharmacy 1 was made on [DATE] after the facility provided a billing authorization. PTC 3 stated that Pharmacy 1 made no other deliveries for [MEDICATION NAME] between [DATE] and [DATE]. On [DATE] at 12:33 p.m., during an observation of Nursing Station 1 Medication Cart 1, Resident 61's [MEDICATION NAME] could not be found in the medication cart. During a concurrent interview, the licensed vocational nurse (LVN 4) stated that he noticed that the [MEDICATION NAME] was unavailable in the facility yesterday and informed the resident's physician and placed a refill order with the pharmacy. LVN 4 stated that the doses scheduled for 9:00 a.m. were marked as unavailable in the [DATE] MAR on ,[DATE] and [DATE]. On [DATE] at 2:34 p.m., during a telephone interview, the registered pharmacist (RPH 2) stated that Pharmacy 2 does deliver two of Resident 61'[MEDICAL CONDITION], but has no record of making any deliveries for either her brand [MEDICATION NAME] or generic [MEDICATION NAME] tablets. A review of Resident 61's February and [DATE] MAR indicated that between ,[DATE] and [DATE], all but two doses (on ,[DATE] and [DATE]) of [MEDICATION NAME] 100 mg were signed as given. On [DATE] at 1:48 p.m., during an interview, LVN 2 stated that he has worked for this facility for approximately a month and was responsible for administering medications to Resident 61, including the 9:00 a.m. dose of [MEDICATION NAME] 100 mg, when she was on Nursing Station 2, however, her room was recently changed and she is now currently on Nursing Station 1. LVN 2 stated that he signed the MAR that several of the 9:00 a.m. doses of [MEDICATION NAME] were given in February 2020 and that his initials

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) on the MAR indicate that the medication was actually administered to the resident. LVN 2 stated that if medications were not given for any reason, he would circle his initials and document the reason on the back of the MAR. LVN 2 denied ever signing Resident 61's MAR that [MEDICATION NAME] was administered without actually giving it to her but could not offer an explanation as to how he was giving the medication when it was unavailable in the facility. LVN 2 stated that he was unable to describe the appearance of a [MEDICATION NAME] 100 mg tablet. LVN 2 stated that if medications were unavailable, he would first check the facility's other medication carts, as residents' rooms are changed frequently, and some medications may not be transferred appropriately. LVN 2 stated that if he could not find a missing medication that way, he would notify the physician and call the pharmacy for a replacement. LVN 2 stated that sometimes he feels that it is impossible to pass medications to all of his residents in the morning within two hours and has to rely on the help of others from time to time to complete his morning medication pass. On [DATE] at 2:35 p.m., Resident 61 was observed in her room lying in her bed with her head elevated. During a concurrent interview, Resident 61 stated that she is familiar with [MEDICATION NAME] and knows it as one of [MEDICAL CONDITION]. Resident 61 stated that sometimes her medications get lost when they move her from room to room. Resident 61 stated that they have made her change rooms five times since her initial admission in [DATE]. Resident 61 stated that she was not sure if they give her the [MEDICATION NAME] 100 mg tablet or not. When shown a picture of what a [MEDICATION NAME] 100 mg tablet looks like, Resident 61 stated that she does not remember receiving any medication that looks like that. On [DATE] at 10:17 a.m., during an interview, the DON stated that Resident 61 receives her medications from two different pharmacies so it is possible that she may have received [MEDICATION NAME] 100 mg from another pharmacy, but stated that she can produce no record of delivery for [MEDICATION NAME] 100 mg from any pharmacy. DON stated that, despite the MAR being signed between [DATE] and [DATE], if it cannot be proven that any [MEDICATION NAME] 100 mg was delivered here, then the most likely explanation is that the [MEDICATION NAME] was not given to Resident 61. The DON stated that it is imperative that residents receive their medications as ordered and that Resident 61 may suffer complications from not receiving [MEDICATION NAME] which could lead to life-threatening infections likely resulting in hospitalization or death. On [DATE] at 10:34 a.m., during a telephone interview, [MEDICAL CONDITION] physician (MD 3) stated that she has been treating Resident 61'[MEDICAL CONDITION] she was an adolescent. MD 3 stated that if Resident 61 does not receive [MEDICAL CONDITION] as prescribed, there is big risk for [MEDICAL CONDITION] to develop resistance to her medications which would cause them not to work anymore. MD 3 stated that [MEDICATION NAME] 100 mg is especially important because it keeps another medication Resident 61 takes [MEDICAL CONDITION].[MEDICATION NAME] (a medication used to treat HIV), at an effective level in her blood. MD 3 stated that Resident 61 has developed resistance to [MEDICAL CONDITION] over her years of treatment and that [MEDICATION NAME] is one of the only fully effective medications left that she can use. MD 3 stated that if Resident 61'[MEDICAL CONDITION] develops resistance to [MEDICATION NAME], it may not be possible to fully treat [MEDICAL CONDITION] the future. MD 3 stated that if Resident 61'[MEDICAL CONDITION] not fully treated, there is a risk that she may develop life-threatening opportunistic infections (infections that occur in people with weak immune systems) which could lead to hospitalization or death. MD 3 stated that if Resident 61'[MEDICAL CONDITION] not fully treated, she may also become more likely to spread [MEDICAL CONDITION] to others. MD 3 stated that she is concerned that Resident 61 has not been receiving her [MEDICATION NAME] as documented in her MAR and thought that the resident living in a skilled nursing facility would help to increase her compliance with her medications to ensure that the medications work in the future. MD 3 stated that she relies heavily on the information in the MAR to inform her treatment decisions and even has her patients bring their MAR with them to their appointments for review. MD 3 stated that she trusts that the medications are being given as they are documented and if the medications were not actually given it may cause her to make incorrect treatment decisions that could put the resident at further risk of harm due to adverse effects (unwanted side effects of medications) of medication doses that are higher than necessary or other unnecessary medications. On [DATE] at 7:50 a.m., during an interview, the ADM stated that he was able to find many other delivery records for [MEDICATION NAME] for Resident 61 and provided additional pharmacy delivery receipts from Pharmacy 1. A review of Pharmacy 1's delivery receipts indicated that a 15-day supply (30 tablets) of [MEDICATION NAME] 100 mg was delivered to the facility for Resident 61 on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. On [DATE] at 8:27 a.m., during a telephone interview, PTC 4 stated that Pharmacy 1 delivered a 15-day supply of the generic [MEDICATION NAME] 100 mg tablets on [DATE] and confirmed that a 15-day supply of the brand [MEDICATION NAME] 100 mg tablets was delivered on ,[DATE], ,[DATE], ,[DATE], ,[DATE], [DATE], and [DATE] for Resident 61. PTC 4 stated that the delivery history given earlier by PTC 3 was for the generic [MEDICATION NAME] only and was under a different prescription number than the brand [MEDICATION NAME]. PTC 4 stated that the eight deliveries Pharmacy 1 made on the dates listed above constitute the entirety of the generic [MEDICATION NAME] or brand [MEDICATION NAME] that was delivered to the facility for Resident 61 and was equal to 120 total days of supply or 240 tablets. PTC 4 stated that, initially, Resident 61 was prescribed the generic [MEDICATION NAME] 100 mg tablets, but her insurance only covered the brand [MEDICATION NAME] and thus was later changed. A review of Resident 61's Resident Census List, dated [DATE], indicated that between [DATE] and [DATE], she was out of the facility for one day ([DATE]) due to a hospital visit. A review of Resident 61's MAR indicated that the facility signed a total of 654 total doses of [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets as administered between [DATE] and [DATE], however, only 240 totals doses were delivered, leaving a total deficit of 414 doses that were signed as given, but unavailable in the facility. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets in any of the facility's emergency kits (kits containing medications for emergency use) or in facility medication supply. RN 1 stated that any medications like that would only be ordered pursuant to a physician's orders [REDACTED]. On [DATE] at 1:13 p.m., during an interview, the DON stated that she agrees that the Resident 61's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MEDICATION NAME] were given when they could not have been. The DON stated that she has been unable to establish that enough [MEDICATION NAME] was ordered to cover the doses signed for. The DON stated that she understands the seriousness of this situation and stated that she wishes the other nurses realized that they are dealing with a human life and that not giving the residents their medications as ordered can kill them. On [DATE] at 3:34 p.m., during an interview, the DON stated that, after searching thoroughly and contacting each pharmacy individually, she was unable to obtain any additional records of delivery for Resident 61's [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets. B. A review of Resident 45's admission record, dated [DATE], indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 45's physician order, dated [DATE], indicated that she was prescribed [MED] HFA to use two puffs by mouth four times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. On [DATE] at 10:40 a.m., during an observation of Nursing Station 2 Medication Cart 3, Resident 45's [MED] could not be found in the medication cart. A review of Resident 45's [DATE] MAR, indicated [MED] was last administered to Resident 45 on [DATE] at 9:00 a.m. During a concurrent interview, LVN 11 stated that she was unable to find the [MED] in the medication cart or anywhere else in the facility. LVN 11 stated that she signed the MAR that she gave Resident 45 her dose of [MED] this morning at 9:00 a.m. even though it was not in available in the medication cart. LVN 11 stated that she should have circled the dose to indicate that it was unavailable but forgot to do so. A review of Resident 45's MAR indicated that a total of 276 doses of [MED] were signed as given between [DATE] and 9:00 a.m. on [DATE]. On [DATE] at 9:20 a.m., during an interview, the DON stated that Pharmacy 1 was the only pharmacy the facility used to supply Resident 45's medications. On [DATE] at 9:24 a.m., during an interview, PTC 1 stated that Pharmacy 1 delivered a 25-day supply of [MED] (one inhaler containing 200 puffs) for Resident 45 on [DATE]. PTC 1 stated that Pharmacy 1 made no other deliveries of this medication for Resident 45. A review of Resident 45's MAR between [DATE] and 9:00 a.m. on [DATE] indicated that as the pharmacy only supplied a 25-day supply, the facility would have only had enough medication to administer [MED] as documented through [DATE]. From [DATE] through 9:00 a.m. on [DATE] a total of 176 additional doses were signed as given (1 omitted) even though the medication was unavailable in the facility. On [DATE] at 10:25 a.m., during an interview, Resident 45 stated that her licensed nurse offered her the [MED] inhaler this morning, but she refused it because she was not familiar with it. Resident 45 stated that she doesn't remember receiving any of that medication since she last came back from the hospital in late [DATE]. On [DATE] at 10:39 a.m., the DON stated that she could not explain how 176 doses of [MED] were signed for when the medication was unavailable in the facility. The DON stated that she would have to ask the nurses what happened. The DON stated that the inhaler could have been saved from before Resident 45's last hospital admission even though she knows that they are not supposed to do that. On [DATE] at 11:11 a.m., during a telephone interview, PTC 2 stated that Pharmacy 1 has never delivered any [MED] for Resident 45 prior to [DATE]. On [DATE] at 11:13 a.m., during an interview, MD 1 stated that although the omission of [MED] for Resident 45

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LVN 9 stated she is familiar with [MED] and confirmed that her initials were on many 9:00 a.m. and 1:00 p.m. doses of [MED] for Resident 45 in the February 2020 MAR. LVN 9 stated that her initials on the MAR indicate that the medication was given. LVN 9 stated that if not given for any reason, she would circle the dose and provide a written explanation on the back. When informed that there was not enough [MED] ordered for Resident 45 to last beyond [DATE], LVN 9 stated that she may have signed doses of [MED] on the MAR without giving them. LVN stated that sometimes she is in a hurry and may have skipped the medications that take a longer time to administer, like breathing treatments. LVN 9 stated that it is possible that she forgot to go back to indicate that the doses were not given, but that it is unlikely since there are so many doses signed for. LVN 9 stated that she has a total of 34 residents to administer medication to and feels like it is difficult to complete in a two-hour period. LVN 9 stated that she tries her best, but sometimes it takes longer because some residents are more difficult than others and require more time. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MED] in any of the facility's emergency kits (kits containing medications for emergency use) or in facility medication supply. RN 1 stated that any medication like that would only be ordered pursuant to a physician's orders [REDACTED]. On [DATE] at 2:48 p.m., during an interview, LVN 11 stated that she failed to indicate on the MAR that the 9:00 a.m. dose of [MED] on [DATE] was not given because she was distracted by the immediate needs of another resident. LVN 11 stated that she should have gone back and circled her initials on that date because the [MED] was not available. LVN 11 states that she understands that her initials on the MAR for a dose indicates that the medication was given. LVN 11 acknowledges that her initials are on many other doses in the February 2020 MAR and stated that I do remember giving her the inhaler. LVN 11 denied signing the MAR that the medication was given without actually giving it but was unable to offer an explanation as to how she administered the inhaler when the resident's supply would have been exhausted by [DATE] or why the resident did not remember receiving it. LVN 11 stated this facility is so disorganized, sometimes medications are missing from the cart due to room changes, and you have to go to the other carts to try to find them. On [DATE] at 1:13 p.m., during an interview, the DON stated that there are no other pharmacy delivery records available for Resident 45's [MED] and confirmed that Pharmacy 1 is the only pharmacy used to supply her medications. The DON agrees that the Resident 45's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MED] were given when they could not have been. The DON stated that she understands the seriousness of this situation and stated that she wishes the other nurses realized that they are dealing with a human life and that not giving the residents their medications as ordered can kill them. C. A review of Resident 7's admission record, dated [DATE], indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) A review of Resident 7's physician's orders [REDACTED].) to inject 20 units subcutaneously (under the skin) every night at bedtime (scheduled for 9:00 p.m.) A review of Resident 7's MAR from [DATE] to [DATE] indicated that 56 doses of [MEDICATION NAME] were signed as administered. A review of Resident 7's MAR from [DATE] indicated that pages 2 and 3 (containing information regarding [MEDICATION NAME] administration in [DATE]) were missing. A review of Resident 7's MAR from [DATE] to [DATE] indicated that 33 doses of [MEDICATION NAME] were signed as administered. On [DATE] at 9:56 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 7's [MEDICATION NAME] could not be found in the medication cart. On [DATE] at 10:33 a.m., during an interview, LVN 2 stated that he could not find Resident 7's [MEDICATION NAME] in the medication cart, the medication storage room, or anywhere else in the facility. A review of Resident 7's pharmacy delivery records indicated Pharmacy 1 delivered one 10 ml vial of [MEDICATION NAME] on [DATE]. On [DATE] at 8:23 a.m., during a telephone interview, the registered pharmacist (RPH 1) confirmed that Pharmacy 1 only delivered one vial of [MEDICATION NAME] for Resident 7 on [DATE]. RPH 1 stated that Pharmacy 1 did not deliver [MEDICATION NAME] for Resident 7 on any other dates. RPH 1 stated that one 10 ml vial of [MEDICATION NAME] is considered a 28-day supply since, per the manufacturer's instructions, it must be used or discarded within 28 days of its first use. A review of Resident 7's MAR indicated that, after [DATE], the [MEDICATION NAME] that Pharmacy 1 had initially supplied would have been expired, however, excluding [DATE] (for which the MAR is unavailable for [MEDICATION NAME]), 60 doses of [MEDICATION NAME] were signed as given between [DATE] and [DATE]. On [DATE] at 9:36 a.m., during a telephone interview, MD 2 stated that he is the attending physician for Resident 7. MD 2 stated that it is imperative that Resident 7 receive her [MEDICATION NAME] as ordered to avoid complication of diabetes. When informed that Resident 7 may have missed several doses of [MEDICATION NAME] even though the MAR was signed indicating those doses were given, MD 2 stated That's wrong. That's so wrong. MD 2 stated that without the [MEDICATION NAME], the resident may experience uncontrolled diabetes which could cause serious health complications resulting in hospitalization or death. MD 2 stated that he would order additional lab tests to assess Resident 7's condition and come by this weekend to reassess her condition personally as her blood sugars have been elevated for several weeks. MD 2 stated that he relies on accurate information from the nursing staff as to what medications were given at the currently prescribed doses in order to guide his treatment decisions. If the medication was not actually given, he would possibly order a higher dose of [MED] than the resident needed leading to complications such as [DIAGNOSES REDACTED] (low blood sugar) that may result in coma or death. On [DATE] at 10:17 a.m., during an interview, the DON agreed that it would have been impossible for Resident 7 to have received her [MEDICATION NAME] after [DATE] since it would have expired 28 days after the initial delivery from Pharmacy 1 on [DATE]. The DON stated that there is no record of any other deliveries for it and Pharmacy 1 is the only pharmacy that supplies medications for Resident 7. The DON stated that it is imperative that residents receive their medications as ordered and that Resident 7 may suffer complications from not receiving her medications as ordered possibly leading to life threatening complications that could result in hospitalization or death. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MEDICATION NAME] in any of the facility's emergency kits or in facility medication supply. RN 1 stated that any medication like that would only be ordered pursuant to a physician's orders [REDACTED]. On [DATE] at 1:13 p.m., during an interview, the DON agreed that the Resident 7's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MEDICATION NAME] were given when they could not have been. On [DATE] at 3:13 p.m., during an interview, LVN 10 stated that she administers [MED] to Resident 7 and is familiar with [MEDICATION NAME]. LVN 10 acknowledged that she signed for multiple doses of [MEDICATION NAME] for Resident 7 on the February 2020 MAR. LVN 10 stated that her initials on the MAR indicated that the medication was given. LVN 10 stated that if for any reason the medication was not given, the initials would be circled and an explanation written on the back of the MAR. LVN 10 stated that Resident 7 has three different types of [MED] and most likely what happened is that she only administered two of them, but signed for all three on the MAR. LVN 10 stated that it was possible that she signed Resident 7's MAR that the [MEDICATION NAME] was given without actually having given it to her. On [DATE] at 3:29 p.m., during an interview, the medical records director (MRD) stated that, after a thorough search, pages 2 and 3 of Resident 7's [DATE] MAR could not be found anywhere in the facility. D. A review of Resident 51's admission record, dated [DATE], indicated that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 51's physician's orders [REDACTED]. A review of Resident 51's MAR indicated that, between [DATE] and [DATE], 19 doses of potassium chloride were signed as given. On [DATE] at 10:42 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 51's potassium chloride could not be found in the medication cart. During a concurrent interview, LVN 2 stated that he was unable to locate Resident 51's potassium chloride in the medication cart or anywhere else in the facility. A review of Resident 51's pharmacy delivery history indicated that Pharmacy 1 delivered a 14-day supply of potassium chloride on [DATE]. A review of Resident 51's MAR indicated that between [DATE] and [DATE], five doses of potassium chloride were signed as given even though the 14-day supply delivered by Pharmacy 1 would not have lasted beyond [DATE]. On [DATE] at 1:13 p.m., the DON stated that there is no other record of delivery for Resident 51's potassium chloride other than the initially supplied 14-day supply and that Pharmacy 1 is the only pharmacy used to supply his medications. The DON agreed that the Resident 51's MAR does not reflect the care actually provided to him and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that five doses of potassium chloride were given when they could not have been. On [DATE] at 3:05 p.m., during an interview, LVN 4 stated that he signed

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Resident 51's MAR that the dose of potassium chloride was given on [DATE] but does not specifically remember giving it. LVN 4 stated that his initials on the MAR indicates that the medication was given and if the medication were not given for any reason, he would circle his initials and document the reason on the back of the MAR. LVN 4 stated that it was possible that he signed Resident 51's MAR that the potassium chloride was given on [DATE] without actually giving him the medication since there would have not been medication available after the [DATE]. A review of the Abuse/Neglect In Service, given in ,[DATE], indicated an example of abuse/neglect would be medication errors is considered neglect. The document indicated the policy for abuse, neglect and abuse reporting that neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and willfully ignoring the needs of a resident. A review of the Abuse Prevention in-service provided on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] indicated, Neglect signs and symptoms include medications improperly administered or not taken as instructed. The document indicated a sign and symptom of neglect is medical treatment not provided. A review of the facility's policy and procedure titled Resident Abuse, undated, indicates that neglect refers to failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness. A review of the facility's policy and procedure document titled Medication Administration-General Guidelines, dated ,[DATE], indicated that: 1. The facility has sufficient staff to allow administering of medications without unnecessary interruptions. 2. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions of if there is any other reason to question the dosage or directions, the physician's orders [REDACTED]. 3. Medications are administered in accordance with written orders of the attending physician. 4. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. 5. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. 6. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time . the space of the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN (as needed) documentation.
F 0642 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a qualified health professional conducts resident assessments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS- an assessment and care screening tool) for one of one sampled resident (Resident 5). This deficient practice had the potential to result in residents not receiving needed treatment or care. Findings: A review of Resident 5's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 5's date of birth was indicated as 11/03/1958. During a concurrent interview and record review on [DATE] at 10:56 a.m., the Final Validation Reports were reviewed with MDS Nurse (MDS 1). MDS 1 verified that the Final Validation Report for Resident 5's MDS indicated that there was an Inconsistent Record Sequence (the type of assessment in this record does not logically follow the type of assessment in the record received prior). MDS 1 stated she did not investigate the warning because she thought it was a software glitch. MDS 1 stated she should have investigated the warning so that she could resubmit a correction to the MDS assessment. MDS 1 confirmed that Resident 5's date of birth did not match their discharge records. MDS 1 stated they should have addressed the warning and fixed the error. During a concurrent interview and record review on [DATE] at 9:37 a.m., the Director of Nursing (DON) stated it was the designated Registered Nurse (RN) MDS coordinator's responsibility to verify accuracy of MDS assessment prior to submission. DON stated that Resident 5's date of birth should have been corrected prior to the MDS discharge assessment being submitted. A review of the facility's policy and procedures titled, Resident Assessment Instrument, revised on September 2010, indicated all person who have completed any portion of the MDS resident assessment form must sign such document attesting to the accuracy of such information. A review of the facility's policy and procedures titled, Electronic Transmission of the MDS, revised on September 2010, indicated the MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the residents' needs for two of six sampled residents (Resident 11 and 26). These deficient practices had the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services. Findings: A. A review of Resident 11's Admission Record (demographic data, resident status, reason of admission) indicated resident was admitted to the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident 11's History and Physical dated 2/11/20, indicated the resident has the capacity to understand and make decisions. A review of Residents 11's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 2/17/20, indicated the resident has severe cognitive (process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 11's Medication Administration Record [REDACTED]. On 3/6/20 at 11:22 a.m., during an observation, Resident 11 was noted yelling and cursing in a loud voice while inside the room and in the hallway. On [DATE] at 8:37 a.m., during an interview and concurrent record review, Licensed Vocational Nurse 2 (LVN 2) confirmed that there was no care plan in place for angry outburst behavior for Resident 11. LVN 2 stated care plan interventions will guide the staff in handling the resident during episode of emotional outburst. LVN 2 also stated that it will help in determining the total number of episodes for the physician in order to assess the need for gradual dose reduction (GDR) or medication adjustments, and non-pharmacological interventions to address the specific behavior before administering prescribed antipsychotic mediations. On [DATE] at 9:00 a.m., during an interview, Registered Nurse 1 (RN 1) stated Resident 11 should have had a care plan to address their angry outburst behavior. A review of Resident 11's Physician order [REDACTED]. To start [MEDICATION NAME] (a medicine (antibiotic) that inhibits the growth of or destroys microorganisms) 500 mg by mouth twice daily for seven days. A review of Resident 11's Licensed Nurses Progress Notes, dated [DATE] at 6:00 p.m. indicated that staff attempted to collect urine specimen, but Resident 11 refused. On 3/6/20 at 9:30 a.m., during an interview and concurrent record review, LVN 2 confirmed that Resident 11's care plan did not include the use of antibiotic [MEDICATION NAME] for urinary tract infection [MEDICAL CONDITION] or the residents refusal for a urine specimen. On [DATE] at 9:50 a.m., during an interview, LVN 1 stated Resident 11's care plan for antibiotic use for UTI should have been initiated to monitor adverse reaction to the medication. LVN 1 stated that Resident 11's urine specimen refusal should have been care planned because it plays an important role to understand the effectiveness of the treatment. A review of the facility's policy and procedures titled, Care Plans Comprehensive, revised on September 2010, indicated each resident's comprehensive care plan incorporate identified problem areas, risk factors, reflect treatment goals, timetables and objectives in measurable outcomes. B. A review of Resident 26's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. by a terrifying event). A review of Resident 26's history and physical examination [REDACTED]. A review of Resident 26's physician's orders [REDACTED]. A review of Resident 26's Medication Administration Record [REDACTED]. During a concurrent interview and record review with Licensed Vocational Nurse 5 (LVN 5) on [DATE] at 10:27 a.m., LVN 5 confirmed no care plan was initiated or created for the use of [MEDICATION NAME]. LVN 5 stated creating a care plan for the use of [MEDICATION NAME] was important so we have a target, goal, and baseline. LVN 5 confirmed care plans would help tailor Resident 26's goals and interventions for his [MEDICAL CONDITION], and allow nurses to see if goals and interventions were appropriate, relevant, and/or required updates and revisions. D. A review of Resident 26's physician's orders [REDACTED]. A review of Resident 26's General Acute Care Hospital (GACH 1) emergency department physician notes dated 3/3/20 indicated the resident states he has been suffering from depression and self-medicates with drugs. Asked someone to bring him [MED]) tonight. He smoked the meth. Per nursing home reports, patient was behaving erratically at the nursing home so they called 911. GACH 1 also indicated, Patient self-reported [MEDICATION

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) NAME] use, and there was no indication for a drug screen. Patient observed for few hours, remains calm. Stable for discharge back to the nursing home. A review of Resident 26's comprehensive care plans indicated no care plan was created for possible [MEDICATION NAME] use upon readmission to the facility. During an interview with the Director of Nursing (DON) on [DATE] at 5:58 p.m., the DON confirmed that there was no initiated care plan for possible [MEDICATION NAME] use upon readmission to the facility. The DON confirmed initiation of a care plan would set goals for the resident's care regarding his potential for illicit drug use while in the facility and would help direct and focus care by the nurses as well as the certified nursing assistants (i.e., supervising visitations, assessing the resident more frequently for abnormal behavior or vital signs, etc.). A review of the facility's policy titled Care Plans-Comprehensive revised 9/2010 indicated The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans when there has been a significant change in the resident's condition, when the desire outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly. The policy indicated, Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision-making.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update the care plan when a resident began showing signs and symptoms of a urinary tract infection [MEDICAL CONDITION] and tested positive for a UTI after obtaining a urine culture for one of two residents sampled (Resident 93). This deficient practice caused Resident 93's care to be compromised as a result due to lack of revisions in goals and interventions. Findings: A review of Resident 93's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 93's history and physical examination [REDACTED]. A review of Resident 93's physician's orders [REDACTED]. A review of Resident 93's physician's orders [REDACTED]. A review of Resident 93's Medication Administration Record [REDACTED]. A review of Resident 93's situation assessment background recommendation (SBAR) communication form dated 3/4/20 indicated the resident had sediment in the urine starting on 3/4/20. The form indicated the resident had discomfort and pain in the scrotum and noted blood around the catheter site. The form indicated the resident had five out of ten pain (on a scale of 0-10, 10 indicating the maximum amount of pain possible). The form also indicated the resident reported seeing stars. The form indicated Resident 93's physician was alerted on 3/5/20 at 3:30 p.m. and the recommendations from the physician included to order labs including a urine analysis and culture (test of urine to identify bacteria), urology (branch of medicine that focuses on surgical and medical diseases of the male and female urinary-tract system) consultation, and to flush the catheter with 30 cubic meter (cc) of normal saline every shift. A review of Resident 93's care plans focusing on indwelling catheters initiated on 10/7/19 indicated the resident was at risk for a UTI due to his indwelling catheter. The goals included bladder will be adequately emptied without complication and will have no bladder distension, pain, and no signs and symptoms of UTI in the next x 3 months. The plan included interventions such as monitoring indwelling catheter, monitoring urine for sediment, cloudiness (not clear), odor, and blood, reporting any of the aforementioned symptoms or signs as well as fever promptly to the physician, and monitoring laboratory results. The care plan had not been updated or revised since 10/7/19. A review of Resident 93's preliminary laboratory results collected on 3/5/20 indicated the resident's urine culture revealed 100,000 colonies/milliliter (mL) of gram negative rods (rod-shaped bacteria) and gram positive cocci (bacteria that has a generally round shape). During an interview with a licensed vocational nurse (LVN 12) on [DATE] at 11:20 a.m., LVN 12 confirmed Resident 93's care plan had not been updated after discovering signs and symptoms of a UTI on 3/4/20. LVN 12 confirmed it was important to update the care plan focusing on indwelling catheter use because it would guide nursing goals, interventions, and care delivery. If the previous care plan goals and interventions were not effective, LVN 12 confirmed it was important to revise the goals and interventions to reduce the incidence of a UTI. A review of the facility's policy titled Care Plans-Comprehensive revised 9/2010 indicated The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans when there has been a significant change in the resident's condition, when the desire outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: A. Notify the physician when one out of eight residents (Resident 51) investigated for quality of care had a blood glucose result greater than 350 milligram per deciliter (mg/dl-unit of measure). B. Assess the external catheter (thin tube) length of a peripherally inserted central catheter (PICC-a long, thin tube is inserted through a vein in the arm and passed through to the larger veins near the heart) upon admission, during dressing changes and obtain an okay to use (an order given by the medical doctor indicating that the medical equipment is cleared for usage by medical staff) order by the physician prior to use for one of three sampled residents (Resident 26). C. Ensure the license nurse who received a physician's telephone order for a warm compress for one of three sampled residents (Resident 83), transcribed the order into the resident's treatment records so that the nursing staff could implement the order. D. Ensure that licensed nurses did not sign the Medication Administration Record ((MAR) - a record of mediations administered to residents) that 414 doses of [MEDICATION NAME] (a medication used to treat Human Immunodeficiency Virus (HIV - [MEDICAL CONDITION] that causes a weakened immune system)) 100 milligrams ((mg) - a unit of measure for mass) were given when unavailable in the facility between 4/6/19 and 3/2/20 for one of 20 observed residents (Resident 61). E. Ensure that licensed nurses did not sign the MAR that 176 doses of [MED] (an inhaled medication used to treat breathing problems) medications were given when unavailable in the facility between 1/18/20 and 3/3/20 for one of 20 observed residents (Resident 45.) F. Ensure that licensed nurses did not sign the MAR that 60 doses of [MEDICATION NAME] (a medication used to treat high blood sugar) were given when unavailable between 12/5/19 and 3/4/20 for one of 20 observed residents (Resident 7.) G. Ensure that licensed nurses did not sign the MAR that five doses of Potassium Chloride ER (a medication used to supplement low potassium levels) eight milliequivalents ((mEq) - a measure of strength for medications like potassium) were given when unavailable between [DATE] and 3/2/20 for one of 20 observed residents (Resident 51). The deficient practice had the potential to place Resident 26,51 and 83 at increased risk of ineffective care management. The deficient practice of signing the MAR that medications were given when they were unavailable in the facility caused the MAR to falsely reflect care provided to Residents 7, 45, 51, and 61. This increased the risk that Residents 7, 45, 51, and 61 could have experienced serious health complications such as respiratory arrest (the inability to breathe), abnormal heart rhythms, coma (a prolonged period of unconsciousness brought on by illness or injury), or life-threatening infections (invasion of the body by disease causing organisms) likely resulting in hospitalization or death. On 3/3/20 at 3:30 p.m., the Department of Public Health (Department) called an Immediate Jeopardy situation (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 (ADM) and director of nursing (DON). On 3/3/20 at 5:48 p.m., the ADM provided the Department with a Plan of Action (POA) which included the following summarized actions: 1. Licensed staff reassessed Resident 61 and found her condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including [MEDICATION NAME], were reordered from the pharmacy on 3/4/20. Resident 61's attending physician (MD 1) ordered lab tests to further assess her condition. 2. Licensed staff reassessed Resident 45 and found her condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including [MED], were reordered from the pharmacy

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) on 3/3/20. Resident 45's attending physician (MD 1) ordered a chest x-ray to further assess her condition. 3. MD 1 indicated that she would reassess Residents 45 and 61 in person on 3/6/20. 4. Licensed staff performed a facility-wide three-way medication cart audit (a check to ensure that the residents' current physician's orders match what is written on their MAR and that the medication cart contains all of the medications necessary for the residents' current physician's orders.) 5. Upon completion of the three-way medication cart audit, licensed staff discovered medications missing for five additional residents. Licensed staff reassessed those additionally affected residents' conditions and found them to be stable with no adverse reactions. Licensed staff notified the affected residents' respective physicians of a change in status due to missing or delayed treatment. Licensed staff reported the resident's respective physicians issued no new orders as a result of the change in status reports. 6. The DON conducted an in-service (training) for all licensed staff on 3/3/30 at 3:00 p.m. to discuss findings and review regulations, policies, and procedures regarding availability of medications, documentation, and reordering medication from the pharmacy. 7. The director of staff development (DSD), DON, and ADM provided disciplinary action to all licensed staff found to be signing the MAR that medications were given to residents when the medications were unavailable in the facility. On 3/5/20 at 9:56 a.m., the Department did a facility-wide random check of medication availability. Resident 7's [MEDICATION NAME] was missing from Nursing Station 2 Medication Cart 2. On 3/5/20 at 12:06 p.m., in a conference meeting with the ADM and DON, the Department informed the facility that the POA was not accepted and Immediate Jeopardy was still in effect due to additional findings. On 3/6/20 at 11:53 a.m., the ADM provided the Department with an amended POA which included the following additional summarized actions: 1. Licensed staff reassessed Resident 7 and found her condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including [MEDICATION NAME], were reordered from the pharmacy on 3/6/20. Resident 7's attending physician (MD 2) ordered lab tests to further assess her condition. 2. Licensed staff performed another facility-wide three-way medication cart audit and found four additional residents were missing medications. Licensed staff reassessed those additionally affected residents' conditions and found them to be stable with no adverse reactions. Licensed staff notified the affected residents' respective physicians of a change in status due to missing or delayed treatment. Licensed staff reported the resident's respective physicians issued no new orders as a result of the change in status reports. 3. The DON and ADM conducted an additional in-service with all licensed staff to reiterate policies, procedures, and protocols regarding medication administration. 4. Pharmacy consultants (professionals hired to help ensure compliance with pharmacy services regulations) performed an additional three-way medication cart audit on 3/6/20. On [DATE] at 10:42 a.m., the Department did a facility-wide random check of medication availability. Resident 51's Potassium Chloride ER 8 mEq was missing from Nursing Station 2 Medication Cart 2. On [DATE] at 1:48 p.m., in a conference meeting with the ADM and DON, the Department informed the facility that the POA was not accepted and Immediate Jeopardy was still in effect due to additional findings. On [DATE] at 7:39 a.m., the ADM provided the Department with an amended POA which included the following additional summarized actions: 1. Licensed staff reassessed Resident 51 and found his condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including Potassium Chloride, were reordered from the pharmacy on [DATE]. Resident 51's attending physician ordered lab tests to further assess his condition. 2. Licensed staff performed another facility-wide three-way medication cart audit and found no additional residents were missing medications. 3. The DON and ADM conducted an additional in-service with all licensed staff to reiterate policies, procedures, and protocols regarding medication administration. On [DATE] at 11:41 a.m., while onsite and after confirming the facility's implementation of the immediate corrective actions, the Department accepted the POA and removed the Immediate Jeopardy, in the presence of the ADM and the DON. Findings: A. A review of Resident 51's admission record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. waste from the blood). A review of Resident 51's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE], indicated the resident was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and required extensive one-person assistance from staff for bed mobility, transfers, ambulation in the corridor, locomotion on and off the unit, dressing, and toilet use. A review of Resident 51's physician's orders, dated [DATE], indicated an order for [REDACTED]. The order indicated to give 10 units (unit of measurement) of [MEDICATION NAME]and to call the medical doctor (MD) for blood sugar greater than 350 mg/dl. On 3/6/20 at 7:47 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 1 (LVN 1) verified that, according to the 2/2020 Medication Administration Record (MAR), Resident 10 had a blood glucose level of 369 mg/dl and was given 10 units of [MEDICATION NAME]by the nurse. When asked if the nurse notified the physician, as indicated by the physician's order, LVN 1 stated she could not find documentation anywhere in the resident's medical record that the physician was notified of the resident's blood glucose being greater than 350 mg/dl. On [DATE] at 2:03 p.m., during an interview, Registered Nurse 1 (RN 1) stated it was important to notify the physician if a resident is hyperglycemic (high blood sugar) because the resident can develop complications such as diabetic ketoacidosis (a serious diabetes complication where the body produces excess blood acids ([MEDICATION NAME])), which can very dangerous for the resident. A review of the facility's policy and procedure titled, Diabetes - Clinical Protocol revised in 4/2015, indicated that the physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care plan. B. A review of Resident 26's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to an infection). A review of Resident 26's history and physical examination [REDACTED]. A review of Resident 26's general acute care hospital (GACH 2) diagnostic radiology consultation report dated 2/11/20 indicated, Right-sided PICC line is present with its tip at the level of the right brachiocephalic junction (vein in the neck). There was no physician's order indicating the PICC was okay to use (MD order and radiographic confirmation of tip placement is required prior to use of the PICC) in the record. A review of Resident 26's physician order for [REDACTED]. The order indicated to measure the external catheter length of PICC upon admission and with each dressing change. A review of Resident 26's intravenous therapy care plan dated 2/19/20 indicated to measure the external catheter length for PICC upon admission and with each dressing change. A review of Resident 26's intravenous therapy medication record dated 2/19/20 through 3/4/20 indicated registered nurses did not fill out the portion of the record asking to measure the external catheter length in centimeters. A review of Resident 26's intravenous therapy medication record dated 2/25/20 through [DATE] indicated a registered nurse (RN) changed the resident's dressing on [DATE] at 10:20 a.m. but did not measure the external catheter length of the PICC as indicated by the physician's order and care plan. During an interview with RN 1 on [DATE] at 1:34 p.m., RN 1 stated registered nurses were responsible for managing, assessing, and administering intravenous therapy through Resident 26's PICC. RN 1 confirmed registered nurses, including herself, did not measure the external catheter length of the PICC per physician's orders and the care plan. RN 1 stated it was important to measure the external catheter length of the PICC upon admission and during every dressing change to make sure that the PICC is in the right place (i.e., in the superior vena cava-a large vein located in the upper chest which collects blood from the head and arms and delivers it back to the right atrium of the heart). RN 1 stated only by measuring the external length upon admission and every dressing change thereafter could RNs properly assess if the catheter had moved and was in the appropriate place. RN 1 confirmed if the tip of the PICC was in the wrong place, it could lead to complications and potentially decrease the effectiveness of medications. RN 1 also stated that Resident 26's PICC was placed in the hospital. When PICCs are placed in the hospital, RN 1 stated the registered nurses do not require an okay to use order by the physician. RN 1 stated usually the hospital records indicated whether a PICC was okay to use. RN 1 confirmed however that she could not locate an okay to use order in Resident 26's hospital records. When asked how RNs would then assess whether the PICC was in the right place if they were not obtaining an okay to use order from the facility's physician or clarifying the information with the hospital, RN 1 confirmed they were only assuming the PICC was in the right place. RN 1 confirmed incorrect placement of a PICC could cause complications in medication delivery and increase. A review of the facility's policy titled General Policies for IV Therapy dated June 2018 indicated confirmation of PICC placement is to be on the resident's chart. A review of the facility's policy titled PICC Dressing Change dated June 2018 indicated length of the external catheter is obtained upon admission and during dressing changes. C. A review of Resident 83's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to an infection), and heart failure (when the heart is unable to pump blood as well as it

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F 0684

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 7)

should) A review of Resident 83's history and physical examination [REDACTED]. A review of Resident 83's optometry examination dated 3/3/20 indicated the resident had upper eyelid [MEDICAL CONDITION] with no discharge and recommended infection treatment and hot compresses. A review of Resident 83's optometrist's telephone order dated 3/3/20 indicated to apply warm cloth compress to left eyelid morning and night for 7 days due to [CONDITION] (a bacterial infection of an oil gland in the eyelid). A review of Resident 83's MAR for the month of March 2020 indicated no order to apply a warm cloth compress to the left eyelid morning and night for 7 days per optometrist's order. During a concurrent interview and record review with licensed vocational nurse 3 (LVN 3) on 3/5/20 at 8:24 a.m., LVN 3 confirmed that there was no warm cloth compress transcribed in Resident 83's MAR. During an interview with Resident 83 on 3/5/20 at 8:36 a.m., Resident 83 stated she never received a warm compress to place on her eye. During a concurrent interview and record review with LVN 5 on 3/5/20 at 2:02 p.m., LVN 5 stated he was the one who transcribed the optometrist's telephone orders into the MAR. LVN 5 confirmed he did not transcribe the order for the warm compress. During an interview with the Director of Nursing (DON) on [DATE] at 7:30 p.m., the DON stated only the nurse taking the telephone order from the physician should be the one who directly writes or transcribes the order into the resident's MAR. The DON confirmed nurses were not following the facility's procedure and as a result the order for warm compress was not provided to the resident. A review of the facility's policy titled Telephone Orders revised February 2014 indicated, Verbal telephone orders may only be received by licensed personnel. Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record.

D. A review of Resident 61's admission record, dated [DATE], indicated that she was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]., dated 4/5/19, indicated that she was prescribed [MEDICATION NAME] 100 mg to be taken by
mouth twice daily at 9:00 a.m. and 5:00 p.m. [MEDICAL CONDITION].A review of Resident 61's MAR between 4/6/19 and 3/2/20 indicated that a total of 654 doses of [MEDICATION NAME] 100 mg were signed as administered to Resident 61 and a total of 10 doses were documented as refused or omitted. On 3/3/20 at 10:05 a.m., during an interview, the medical records director (MRD) stated that he could not find any record of pharmacy delivery history for Resident 61's [MEDICATION NAME] but knows that the resident uses two different pharmacies to deliver [MEDICAL CONDITION] (Pharmacy 1 and Pharmacy 2.) On 3/3/20 at 10:51 a.m., during a telephone interview, the pharmacy technician (PTC 3) stated that Pharmacy 1 only had records of delivering a 15-day supply of [MEDICATION NAME] (the generic name for [MEDICATION NAME]) 100 mg for Resident 61 on 4/6/19.
PTC 3 stated that another order was placed on 2/11/20 but was not delivered due to insurance reasons. PTC 3 stated that the most recent delivery from Pharmacy 1 was made on 3/3/20 after the facility provided a billing authorization. PTC 3 stated that Pharmacy 1 made no other deliveries for [MEDICATION NAME] between 4/6/19 and 3/3/20. On 3/3/20 at 12:33 p.m., during an observation of Nursing Station 1 Medication Cart 1, Resident 61's [MEDICATION NAME] could not be found in the medication cart. During a concurrent interview, the licensed vocational nurse (LVN 4) stated that he noticed that the [MEDICATION NAME] was unavailable in the facility yesterday and informed the resident's physician and placed a refill order with the pharmacy. LVN 4 stated that the doses scheduled for 9 a.m. were marked as unavailable in the March 2020 MAR on 3/2 and 3/3/20. On 3/3/20 at 2:34 p.m., during a telephone interview, the pharmacist (RPH 2) stated that Pharmacy 2 does deliver two of Resident 61'[MEDICAL CONDITION] but has no record of making any deliveries for either her brand [MEDICATION NAME] or generic [MEDICATION NAME] tablets. A review of Resident 61's February and March 2020 MAR indicated that between 2/11 and
[DATE], all but two doses (on 2/12 and [DATE]) of [MEDICATION NAME] 100 mg were signed as given. On 3/4/20 at 1:48 p.m., during an interview, LVN 2 stated that he has worked for this facility for approximately a month and was responsible for administering medications to Resident 61, including the 9 a.m. dose of [MEDICATION NAME] 100 mg, when she was on Nursing Station 2, however, her room was recently changed and she is now currently on Nursing Station 1. LVN 2 stated that he signed the MAR that several of the 9 a.m. doses of [MEDICATION NAME] were given in February 2020 and that his initials on the MAR indicate that the medication was actually administered to the resident. LVN 2 stated that if medications were not given for any reason, he would circle his initials and document the reason on the back of the MAR. LVN 2 denied ever signing Resident 61's MAR that [MEDICATION NAME] was administered without actually giving it to her but could not offer an explanation as to how he was giving the medication when it was unavailable in the facility. LVN 2 stated that he was unable to describe the appearance of a [MEDICATION NAME] 100 mg tablet. LVN 2 stated that if medications were unavailable, he would first check the facility's other medication carts, as residents' rooms are changed frequently, and some medications may not be transferred appropriately. LVN 2 stated that if he could not find a missing medication that way, he would notify the physician and call the pharmacy for a replacement. LVN 2 stated that sometimes he feels that it is impossible to pass medications to all of his residents in the morning within two hours and has to rely on the help of others from time to time to complete his morning medication pass. On 3/4/20 at 2:35 p.m., Resident 61 was observed in her room lying in her bed with her head elevated. During a concurrent interview, Resident 61 stated that she is familiar with [MEDICATION NAME] and knows it as one of [MEDICAL CONDITION]. Resident 61 stated that sometimes her medications get lost when they move her from room to room. Resident 61 stated that they have made her change rooms five times since her initial admission in April 2019. Resident 61 stated that she was not sure if they give her the [MEDICATION NAME] 100 mg tablet or not. When shown a picture of what a [MEDICATION NAME] 100 mg tablet looks like, Resident 61 stated that she does not remember receiving any medication that looks like that. On 3/6/20 at 10:17 a.m., during an interview, the DON stated that Resident 61 receives her medications from two different pharmacies so it is possible that she may have received [MEDICATION NAME] 100 mg from another pharmacy, but stated that she can produce no record of delivery for [MEDICATION NAME] 100 mg from any pharmacy. DON stated that, despite the MAR is being signed between 5/5/2019 and 3/3/20, if it cannot be proven that any [MEDICATION NAME] 100 mg was delivered here, then the most likely explanation is that the [MEDICATION NAME] was not given to Resident 61. The DON stated that it is imperative that residents receive their medications as ordered and that Resident 61 may suffer complications from not receiving [MEDICATION NAME] which could lead to life-threatening infections likely resulting in hospitalization or death. On 3/6/20 at 10:34 a.m., during a telephone interview, [MEDICAL CONDITION] physician (MD 3) stated that she has been treating Resident 61'[MEDICAL CONDITION] she was an adolescent. MD 3 stated that if Resident 61 does not receive [MEDICAL CONDITION] as prescribed, there is big risk for [MEDICAL CONDITION] to develop resistance to her
medications which would cause them not to work anymore. MD 3 stated that [MEDICATION NAME] 100 mg is especially important
because it keeps another medication Resident 61 takes [MEDICAL CONDITION].[MEDICATION NAME] (a medication used to treat
HIV), at an effective level in her blood. MD 3 stated that Resident 61 has developed resistance to [MEDICAL CONDITION] over her years of treatment and that [MEDICATION NAME] is one of the only fully effective medications left that she can use. MD 3 stated that if Resident 61'[MEDICAL CONDITION] develops resistance to [MEDICATION NAME], it may not be possible to fully
treat [MEDICAL CONDITION] the future. MD 3 stated that if Resident 61'[MEDICAL CONDITION] not fully treated, there is a risk that she may develop life-threatening opportunistic infections (infections that occur in people with weak immune systems) which could lead to hospitalization or death. MD 3 stated that if Resident 61'[MEDICAL CONDITION] not fully treated, she may also become more likely to spread [MEDICAL CONDITION] to others. MD 3 stated that she is concerned that Resident 61 has not been receiving her [MEDICATION NAME] as documented in her MAR and thought that being in a skilled nursing facility would help to increase her compliance with her medications to ensure that the medications work in the future. MD 3 stated that she relies heavily on the information in the MAR to inform her treatment decisions and even has her patients bring their MAR with them to their appointments for review. MD 3 stated that she trusts that the medications are being given as they are documented and if the medications were not actually given it may cause her to make incorrect treatment decisions that could put the resident at further risk of harm due to adverse effects (unwanted side effects of medications) of higher doses or other medications. On [DATE] at 7:50 a.m., during an interview, the ADM stated that he was able to find many other delivery records for [MEDICATION NAME] for Resident 61 and provided additional pharmacy delivery receipts from Pharmacy 1. A review of Pharmacy 1's delivery receipts indicated that a 15-day supply (30 tablets) of [MEDICATION NAME] 100 mg was delivered to the facility for Resident 61 on the following dates: 4/25/19, 5/2[DATE]9, 6/28/19, 8/29/19, 11/28/19, 12/19/19, 1/1/20. On [DATE] at 8:27 a.m., during a telephone interview, PTC 4 stated that Pharmacy 1 delivered a 15-day supply of the generic [MEDICATION NAME] 100 mg tablets on 4/6/19 and confirmed that a 15-day supply of the brand [MEDICATION NAME] 100 mg tablets was delivered on 4/25, 5/24, 6/28, 8/29, 11/28, 12/19/19, and 1/1/20 for Resident 61. PTC 4 stated that the delivery history given earlier by PTC 3 was for the generic [MEDICATION NAME] only and was under a different prescription number than the brand [MEDICATION NAME]. PTC 4 stated that the eight deliveries Pharmacy 1 made on the dates listed above constitute the entirety of the generic [MEDICATION NAME] or brand [MEDICATION NAME] that was delivered to the facility for Resident 61 and was equal to 120 days of supply or 240 tablets. PTC 4 stated

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) that, initially, Resident 61 was prescribed the generic [MEDICATION NAME] 100 mg tablets, but her insurance only covered the brand [MEDICATION NAME] and thus was later changed. A review of Resident 61's Resident Census List, dated 3/4/20, indicated that between 4/5/19 and 3/2/20, she was out of the facility for one day (2/12/20) due to a hospital visit. A review of Resident 61's MAR indicated that the facility signed a total of 654 total doses of [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets as administered between 4/6/19 and 3/2/20, however, only 240 totals doses were delivered, leaving a total deficit of 414 doses that were signed as given, but unavailable in the facility. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets in any of the facility's emergency kits (kits containing medications for emergency use) or in facility medication supply. RN 1 stated that any medications like that would only be ordered pursuant to a physician's order and would be specific to that resident for whom it was prescribed. On [DATE] at 1:13 p.m., during an interview, the DON stated that she agrees that the Resident 61's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MEDICATION NAME] were given when they could not have been. The DON stated that she has been unable to establish that enough [MEDICATION NAME] was ordered to cover the doses signed for. The DON stated that she understands the seriousness of this situation and stated that she wishes the other nurses realized that they are dealing with a human life and that not giving the residents their medications as ordered can kill them. On [DATE] at 3:34 p.m., during an interview, the DON stated that, after searching thoroughly and contacting each pharmacy individually, she was unable to obtain any additional records of delivery for Resident 61's [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets. E. A review of Resident 45's admission record, dated [DATE], indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) A review of Resident 45's physician order, dated 12/23/19, indicated that she was prescribed [MED] HFA to use two puffs by mouth four times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. On 3/2/20 at 10:40 a.m., during an observation of Nursing Station 2 Medication Cart 3, Resident 45's [MED] could not be found in the medication cart. A review of Resident 45's March 2020 MAR, indicated [MED] was last administered to Resident 45 on 3/2/20 at 9:00 a.m. During a concurrent interview, LVN 11 stated that she was unable to find the [MED] in the medication cart or anywhere else in the facility. LVN 11 stated that she signed the MAR that she gave Resident 45 her dose of [MED] this morning at 9 a.m. even though it was not in available in the medication cart. LVN 11 stated that she should have circled the dose to indicate that it was unavailable, but forgot to do so. A review of Resident 45's MAR indicated that a total of 276 doses of [MED] were signed as given between 12/23/19 and 9 a.m. on 3/2/20. On 3/3/20 at 9:20 a.m., during an interview, the DON stated that Pharmacy 1 was the only pharmacy the facility used to supply Resident 45's medications. On 3/3/20 at 9:24 a.m., during an interview, PTC 1 stated that Pharmacy 1 delivered a 25-day supply of [MED] (one inhaler containing 200 puffs) for Resident 45 on 12/23/19. PTC 1 stated that Pharmacy 1 made no other deliveries of this medication for Resident 45. A review of Resident 45's MAR between 12/23/19 and 9 a.m. on 3/2/20 indicated that as the pharmacy only supplied a 25-day supply, the facility would have only had enough medication to administer [MED] as documented through [DATE]. From 1/18/20 through 9 a.m. on 3/2/20 a total of 176 additional doses were signed as given (1 omitted) even though the medication was unavailable in the facility. On 3/3/20 at 10:25 a.m., during an interview, Resident 45 stated that her licensed nurse offered her the [MED] inhaler this morning, but she refused it because she was not familiar with it. Resident 45 stated that she doesn't remember receiving any of that medication since she last came back from the hospital in [DATE]. On 3/3/20 at 10:39 a.m., the DON stated that she could not explain how 176 doses of [MED] were signed for when the medication was unavailable in the facility. The DON stated that she would have to ask the nurses what happened. The DON stated that the inhaler could have been saved from before Resident 45's last hospital admission even though she knows that they are not supposed to do that. On 3/3/20 at 11:11 a.m., during a telephone interview, PTC 2 stated that Pharmacy 1 has never delivered any [MED] for Resident 45 prior to 12/23/19. On 3/06/20 at 11:13 a.m., during an interview, MD 1 stated that although the omission of [MED] for Resident 45
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 10) investigated for accidents had floor mats in place while in bed as ordered by the physician. This deficient practice had the potential to increase the resident's risk of sustaining injuries in the event of a fall. Findings: A review of Resident 10's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 10's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/27/19, indicated the resident had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required extensive one-person assistance from staff for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A review of Resident 10's physician's orders [REDACTED]. Monitor placement every shift. On 3/2/20 at 9:05 a.m., during an observation, Resident 10 was awake in bed. No floor mats were observed at the resident's bedside. On 3/3/20 at 4:38 p.m., during an observation, Resident 10 was in bed. No floor mats were observed at the resident's bedside. On 3/6/20 at 7:39 a.m., during an observation, Resident 10 was awake in bed. No floor mats were observed at the resident's bedside. On 3/6/20 at 9:11 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 1 (LVN 1) stated that Resident 10 had a history of [REDACTED]. On 3/6/20 at 9:18 a.m., during a concurrent observation and interview, Licensed Vocational Nurse 1 (LVN 1) verified that Resident 10 did not have floor mats in place while the resident was in bed. On [DATE] at 1:59 p.m., during an interview, Registered Nurse 1 (RN 1) stated it was important for Resident 10 to have the floor mats in place while he was in bed because he also had [MEDICAL CONDITION] episodes, and the floor mats would help prevent injuries if the resident ever fell to the floor. A review of the facility's policy and procedure titled, Falls and Fall Risk, Management, revised in 12/2007, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly manage an indwelling catheter (a tube inserted into the bladder and left in place to drain urine into a collection bag) for one of two sampled residents (Resident 93) by not: 1. Notifying the physician immediately upon assessing signs and symptoms of a urinary tract infection (infection in any part of the urinary system). 2. Securing the indwelling catheter to keep from pulling, tugging, or accidental dislodgement (being forced out). 3. Obtaining a physician's order prior to flushing the indwelling catheter (a process of irrigating the catheter with a solution to ensure the catheter does not become clogged). 4. Inserting a new indwelling catheter prior to obtaining a urine culture (a test that can detect bacteria in the urine). These deficient practices resulted in delayed assessment, treatment, and care and had the potential to cause a urinary infection that could lead [MEDICAL CONDITION] (potentially life-threatening condition caused by the body's response to an infection). Findings: A. A review of Resident 93's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 93's history and physical examination [REDACTED]. A review of Resident 93's physician's order dated 11/22/19 indicated an indwelling catheter was prescribed for wound management. A review of Resident 93's physician's order dated 11/22/19 indicated to monitor urine output for sediment, cloudiness, and hematuria (blood in the urine) every shift. A review of Resident 93's Medication Administration Record [REDACTED]. A review of Resident 93's care plans focusing on indwelling catheters initiated on 10/7/19 indicated the resident was at risk for a UTI due to his indwelling catheter. The goals included bladder will be adequately emptied without complication and will have no bladder distension, pain, and no signs and symptoms of UTI in the next x 3 months. The plan included interventions such as monitoring indwelling catheter, monitoring urine for sediment, cloudiness (not clear), odor, and blood, reporting any of the aforementioned symptoms or signs as well as fever promptly to the physician, and monitoring laboratory results. During an observation on 3/2/20 at 8:09 a.m., the resident was observed lying in bed.

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) Resident 93 had an indwelling catheter that was hanging on the side of his bed. Sediment (small particles observed in the urine) was observed in the tubing and the bag. During a subsequent observation on 3/5/20 at 3:29 p.m., the resident's indwelling catheter was observed with the licensed vocational nurse (LVN 12). LVN 12 confirmed there was sediment in the urine and blood around the catheter (tubing) insertion site. During an interview with Resident 93 on 3/5/20 at 3:31 p.m., the resident stated he noticed his urine had been cloudy with sediment for the past few days. He also stated he felt a burning sensation. The resident stated he told LVN 12 about his symptoms and requested for a urine culture because he thought he might have a UTI on 3/4/20. During a subsequent interview with LVN 12 on 3/5/20 at 3:45 p.m., LVN 12 stated she began noticing sediment in Resident 93's catheter in the morning on 3/4/20 while providing catheter care around 10:00 a.m. LVN 12 stated she did not tell the physician immediately because she was busy. LVN 12 stated before leaving her shift on 3/4/20, Resident 93 told her he was having symptoms of a urinary tract infection. LVN 12 stated because she was just about to leave, she told the resident she would notify his physician when she came back the next day on 3/5/20. LVN 12 stated she did not endorse the information to any other nurse or registered nurse supervisor when Resident 93 notified her of his symptoms at the end of her shift on 3/4/20 because it was the end of her shift and she had to go home. LVN 12 confirmed as a result, Resident 93 received delayed care (i.e., obtaining a urine culture, assessment by the registered nurse, initiation of antibiotics (medication used to treat bacterial infections)) and could have the potential to develop a worsening infection. A review of the facility's policy titled Change in a Resident's Condition or Status revised September 2013 indicated our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. B. During a concurrent observation and interview on 3/5/20 at 3:29 p.m., LVN 12 was observed providing indwelling catheter care (cleaning the catheter and the genital area around the insertion site) for Resident 93. The indwelling catheter was not secured to the resident's leg and was pulling on his genital area. LVN 12 confirmed it was the facility's policy to ensure the indwelling catheter was secured to Resident 93's leg at all times to prevent the catheter from pulling or tugging at the insertion site, which could lead to trauma and injury. A review of the facility's policy titled Catheter Care, Urinary revised September 2014 indicated to secure catheter utilizing a leg band. C. During an interview with LVN 12 on 3/5/20 at 3:05 p.m., LVN 12 stated she flushed Resident 93's indwelling catheter on 3/4/20 upon seeing sediment (particles in the urine) to determine if the urine continued to produce sediment thereafter. A review of Resident 93's current physician's orders indicated no order to flush or irrigate the catheter upon seeing sediment (particles in the urine). During a subsequent interview with LVN 12 on 3/5/20 at 3:45 p.m., LVN 12 stated she thought there was an order to flush the indwelling catheter upon seeing sediment. LVN 12 confirmed there was no physician's order and she should not have flushed Resident 93's catheter without obtaining a physician's order first per the facility policy. A review of the facility's policy titled Catheter Care, Urinary revised September 2014 indicated, Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction. D. A review of Resident 93's physician's order dated 11/22/19 indicated to change the indwelling catheter every month and as needed for dislodgement or leaking. A review of Resident 93's Treatment Administration Record (TAR) for the month of February 2020 indicated Resident 93's indwelling catheter was last changed on 2/12/20. A review of Resident 93's physician's order dated 3/5/20 indicated to obtain a urine culture STAT (medical term for immediately). During an interview with LVN 12 on [DATE] at 10:52 a.m., LVN 12 stated upon receiving the physician's order, she obtained urine from Resident 93's existing urinary catheter by accessing the port (area of the indwelling catheter where a syringe can be inserted to obtain a urine sample). During an interview with the quality assurance nurse (LVN 5) on [DATE] at 11:20 a.m., LVN 5 stated if the urine is cloudy or there is sediment in the catheter, nurses should obtain an order for [REDACTED]. A review of the facility's policy titled Collecting a Urine Specimen from a Closed Drainage System revised 10/2010 indicated the purpose of the procedure is to obtain an uncontaminated urine specimen from a resident with a catheter. An article published by the U.S. National Library of Medicine, National Institutes of Health titled Catheter associated urinary tract infections dated 7/25/14 indicated, A mature biofilm (a community of bacteria that attach to a surface) has usually formed once the catheter has been in situ (in position) for longer than 2 weeks. Urine collected through these catheters are contaminated by organisms present in the biofilm. There is a greater number of species and quantity of organisms isolated than these specimens compared with bladder urine collected simultaneously. Thus, it is recommended that the catheter be removed and a new catheter inserted, with specimen collection from the freshly placed catheter, before antimicrobial therapy (medication used to treat a bacterial infection) is initiated for symptomatic infection (an infection that presents with symptoms).
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one out of one resident (Resident 10) investigated for hydration, who was on fluid restriction, was being monitored for fluid intake and output as ordered by the physician. This deficient practice had the potential to either place the resident at risk for excess fluid volume or dehydration. Findings: A review of Resident 10's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 10's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/27/19, indicated the resident had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required extensive one-person assistance from staff for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A review of Resident 10's physician's orders [REDACTED].= 120 ml, 3-11 = 100 ml, 11-7 = 60 ml; Dietary: breakfast = 360 ml, lunch = 120 ml, and dinner = 240 ml. A review of Resident 10's physician's orders [REDACTED]. On 3/6/20 at 11:47 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 1 (LVN 1) verified that Resident 10 had a physician's orders [REDACTED]. and output in the month of January 2020, starting on 1/24/20. However, LVN 1 was not able to find any documentation that nurses were documenting the resident's intake and output in the month of February 2020. On [DATE] at 2:08 p.m., during an interview, when asked why it was important for the nurses to monitor Resident 10's intake and output, Registered Nurse 1 (RN 1) stated that the resident was retaining water, and it was important for the nurses to monitor the resident's intake and output because it could become dangerous if the resident retained too much water. RN 1 stated that water retention for this resident could be very damaging to his body system. A review of the facility's policy and procedure titled, Intake, Measuring and Recording, revised in 10/2010, indicated the purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. The following information should be recorded in the resident's medical record, per facility guidelines: (1) The date and time the resident's fluid intake was measured and recorded, (2) The name and title of the individual who measured and recorded the resident's fluid intake, (3) The amount (in mLs) of liquid consumed, (4) The type of liquid consumed (i.e. tea, milk, coffee, soup, etc.), (5) If the resident refused the treatment, the reason(s) why and the interventions taken, and (6) The signature and title of the person recording the data.
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.** Based on observation, interview, and record review, the facility failed to provide its licensed nurses with adequate training and orientation to ensure competency in administering medications. This deficient practice resulted in four of 20 sampled residents (Resident 7,45,51 and 65) not receiving their medications as ordered by the physician. This increased the risk that Residents 7, 45, 51, and 61 could have experienced serious health complications such as respiratory arrest (the inability to breathe), abnormal heart rhythms, coma (a prolonged period of unconsciousness brought on by illness or injury), or life-threatening infections (invasion of the body by disease causing organisms) likely resulting in hospitalization or death. Findings: A review of the facility's Competency Training Checklist indicated there was no area allotted on the form to document an employees' competencies with regards to medication administration or documentation. During a concurrent record review and interview with the Director of Nurses (DON) on 3/09/20 01:53 p.m., the DON was asked why the Competency Training Checklist form did not indicate an area for medication administration. The DON stated that area will be added and assessed on the form. The DON stated there is not a policy or procedure that stipulates the process for assessment requirements for licensed nurses medication pass competencies. During an interview with the DON on 3/11/20 05:10 p.m., the DON stated she will update the Competency Training Checklist to include a section for Medication administration pass in order to keep track of the nurse's progress and to identify specific areas of weakness in order to provide

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) additional training. A review of the Facility Assessment, dated 10/ 2019, noted that a competency for medication administration should be indicated. A review of the facility's policy and procedure titled, Medication Ordering and Receiving from the Dispensing Pharmacy, reviewed 1/23/20, indicated that medications that need to be refilled is to be called in, faxed or otherwise transmitted to the pharmacy. The policy indicated that a licensed nurse receives medications delivered to the facility and documents that the delivery was received and was secure on the medication delivery receipt. The policy indicated a licensed nurse promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on observation, interview and record review, the facility failed to ensure that the Daily Nursing Staffing Posting (positing information that contains the calculation of the amount of hours worked by staff for resident care) of actual hours worked, was posted on a daily basis. This deficient practice resulted with the total number of staff and the actual hours worked by the staff not being readily accessible to residents and visitors. Findings: During an observation on 3/2/20 at 8:30 a.m., the Daily Nursing Staffing Posting dated 3/2/20 was noted near the entrance lobby. The posting displayed the projected (estimated amount of hours) Direct Care Service Hours Per Patient Day (DHPPD). The previous days ([DATE]) actual nursing hours were not noted on the posting. During an interview on [DATE] at 10:28 a.m., the Director of Staff Development Assistant (DSDA) stated that she calculates the actual number of Direct Care Service Hours Per Patient Day (DHPPD) after each shift based on the nursing staffing sign in sheet signatures. During an interview on [DATE] at 10:28 a.m., the Director of Staff Development (DSD) stated that they don't compute, update and post actual nursing total direct care hours per shift. DSD states that they do the actual calculation of the DHPPD after 24 hrs of the shift worked, but they do not post the actual hour calculation. A record review of the Daily Nursing Staffing Posting for the following dates: 3/2/20, 3/3/20, 3/4/20, 3/5/20, 3/8/20, [DATE], and [DATE] indicates that only the projected hours were displayed. During an interview on [DATE] at 8:33 a.m., the Administrator stated he was not aware of the policy of posting actual nursing hours worked every shift. A review of the facility's policy and procedures titled, Posting Direct Care Daily Staffing Numbers, revised on 8/2006, indicated within two hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the nursing staff directly responsible for resident care form. The shift supervisor shall date the form, record the census and post the staffing information in the location designated by the administrator.
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: 1. Provide medications pursuant to physicians' orders for four of 21 observed residents (Residents 7, 46, 51, and 301.) 2. Accurately account for two doses of controlled substances (medications with a high potential for abuse) for two residents (Residents 43 and 66) in one of two inspected medication carts (Station 1 Medication Cart 1.) The deficient practice of failing to supply medications pursuant to physicians' orders increased the risk that Residents 7, 46, 51, and 301 would not have medications available in the facility to treat their conditions which could have adversely affected their health and well-being. The deficient practice of failing to accurately account for the use of controlled substances increased the risk that medications may not be available for Residents 43 and 66 when needed and also increased the facility's risk for the potential loss, diversion (transfer of a medication from a legal to an illegal use), or accidental exposure to controlled substances. Findings: 1. Review of Resident 301's admission record, dated 3/5/20, indicated that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) A review of Resident 301's physician's orders [REDACTED]. On 3/4/20 at 8:15 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 301's [MED] could not be found in the medication cart. During a concurrent interview, the Licensed Vocational Nurse 2 (LVN 2) stated that he was unable find Resident 301's [MED] in the medication cart, on any of the other medication carts, in the medication storage room, or anywhere else in the facility. A review of Resident 7's admission record, dated [DATE], indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) Review of Resident 7's physician's orders [REDACTED].) to inject one ml subcutaneously (under the skin) once daily on Mondays, Wednesdays, and Fridays. On 3/5/20 at 9:56 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 7's [MED] could not be found in the medication cart. On 3/5/20 at 10:33 a.m. LVN 2 stated that he could not find Resident 7's [MED] in the medication cart, on any of the other medication carts, in the medication storage room refrigerator, or anywhere else in the facility. A review of Resident 46's admission record, dated [DATE], indicated that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. [REDACTED]. On [DATE] at 9:56 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 46's [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg could not be found in the medication cart. On [DATE] at 10:33 a.m., during an interview, LVN 2 stated that he could not find Resident 46's [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg in the medication cart, on any of the other medication carts, in the medication storage room, or anywhere else in the facility. A review of Resident 51's admission record, dated 2/28/20, indicated that he was admitted to the facility on ,[DATE] with [DIAGNOSES REDACTED].) A review of Resident 51's physician's orders [REDACTED]. On [DATE]20 at 10:42 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 51's [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg could not be found in the medication cart. On [DATE]20 at 1:10 p.m., during an interview, LVN 2 stated that he could not find Resident 51's [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg in the medication cart, on any of the other medication carts, in the medication storage room, or anywhere else in the facility. 2. On 3/5/20 at 2:26 p.m., during an observation of Nursing Station 1 Medication Cart 1, the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): A. Resident 43's Controlled Drug Record for [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg indicated that there were eight doses left, however, the medication card only contained seven doses. B. Resident 66's Controlled Drug Record for testosterone (an injectable medication used to raise levels of the testosterone hormone in the blood) 200 mg/ milliliter ((ml) - a unit of measure for volume) indicated that there were two doses left, however, the medication cart only contained one dose. On 3/5/20 at 2:57 p.m., during an interview, Licensed Vocational Nurse 4 (LVN 4) stated that he administered both the missing dose of [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg for Resident 43 and testosterone 200 mg/ml for Resident 66 this morning but failed to sign their respective Controlled Drug Records for those doses. LVN 4 stated that It is not easy working here, sometimes you get pulled from room to room and you forget. LVN 4 stated that he is aware that he is required to sign the Controlled Drug Record immediately after the medication is given to maintain accountability of controlled substances.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pharmacy consultant conducted monthly medication regimen review (MRR) for one of three resident (Resident 7) investigated under unnecessary medications review of [MED] (hormone that works by lowering levels of glucose (sugar) in the blood). This deficient practice had the potential to cause Resident 7 to receive an unnecessary medication and can lead to adverse side effects. Findings: A review of Resident 7's Admission Record indicated resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 7's initial history report completed on 11/6/19, indicated resident has the capacity to understand and make decisions. A review of Resident 7's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 2/12/20, indicated resident have intact cognitive (thinking process) function. A review of Resident 7's order summary report on 11/5/19, indicated the following orders: 1. [MED] [MED] (fast-acting [MED] that starts to work about 15 minutes after injection) coverage subcutaneously (under the skin) per sliding scale (a certain amount of [MED] given with regards to a residents blood sugar levels) before meals and at bed time. 2. [MED] Mix 75/25 Suspension (mixture of rapid acting and intermediate acting [MED])100 Unit/milliliter (U/ml -unit of measurement), inject 20 unit subcutaneously two times a day for diabetes mellitus. 3. [MED] [MEDICATION NAME] Solution (long acting [MED]) 100 U/ML, inject 20 unit subcutaneously at bedtime for

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) diabetes mellitus. A review of Skilled Nursing Pharmacy monthly MRR dated 12/1/19, 1/1/20, and 2/1/20 indicated that Resident 7's [MED] medication was not reviewed by the pharmacy consultant. On 3/6/20 at 11:00 a.m., during a phone conversation interview, Pharmacist (RPH 3) stated that he was not able to conduct Resident 7's MRR for the use of [MED] since admission. RPH 3 stated that without pharmacy recommendation to follow up blood test such as Hemoglobin A1C (H A1C- lab test that looks at the average amount of sugar in your blood over a 3 month period), it would be difficult to managed DM wherein the blood sugar will be high and cannot be controlled. On 3/6/20 at 11:29 a.m., during an interview, the Director of Nursing (DON), DON stated Resident 7's MRR should be reviewed monthly by the facility's pharmacy consultant to follow up recommendations and to prevent irregularities and monitoring for DM management. DON stated if there's no monthly MRR for Resident 7's [MED] medication, it could potentially lead to high blood sugar that is difficult to managed. A review of the facility's policy and procedures titled, Medication Regimen Reviews, revised on 4/ 2007, indicated the consultant pharmacy will perform a (MRR) for every resident in the facility. Routine reviews will be done monthly. The primary purpose of this review is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one resident (Resident 51) who was diabetic, was ordered a Hemoglobin A1c (HbA1c - test that tells you your average level of blood sugar over the past 2 to 3 months) level to ensure the effectiveness of his treatment. This deficient practice had the potential for improper blood sugar control which can lead to higher risk of diabetes complications. Findings: A review of Resident 51's admission record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 51's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE], indicated the resident was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and required extensive one-person assistance from staff for bed mobility, transfers, ambulation in the corridor, locomotion on and off the unit, dressing, and toilet use. A review of Resident 51's medical record indicated that the resident had not been ordered a Hemoglobin A1c (HbA1c - test that tells you your average level of blood sugar over the past 2 to 3 months). On 3/6/20 at 7:47 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 1 (LVN 1) confirmed that Resident 51 was diabetic and required the use of [MED]. LVN 1 stated she could not find a physician's orders [REDACTED]. LVN 1 stated that, normally, when a resident with a [DIAGNOSES REDACTED]. When asked if the resident had HbA1c results from the general acute care hospital (GACH) where he was admitted from, LVN 1 stated she could not find any lab results for HbA1c. On [DATE] at 2:03 p.m., during an interview, Registered Nurse 1 (RN 1) stated it is important for diabetic residents to be monitored for HbA1c in order to determine the effectiveness of the resident's treatment. A review of the facility's policy and procedure titled, Diabetes - Clinical Protocol, revised in 3/2015, indicated that the physician will order appropriate lab tests (for example, periodic finger sticks or A1c) and adjust treatments based on these results and other parameters such as glycosuria (excretion of glucose into the urine), weight gain or loss, hypoglycemic (low blood sugar) episodes, etc. Monitor A1c on admission (if no results from a previous test are available) or when diabetes is diagnosed , and every 6 months thereafter.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide non-pharmalogical interventions (i.e., reducing noise levels at night, exercise during the day, etc.) prior to the initiation of a [MEDICAL CONDITION] medication (any medication that affects brain activities associated with mental processes and behaviors) and failed to indicate what specific behavior led to the prescription of a [MEDICAL CONDITION] medication for one of five sampled residents (Resident 26). This deficient practice had the potential to negatively impact Resident 26's health and well-being by causing preventable medication-related adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) including, but not limited to: drowsiness, dizziness, and increased risk of fall. Findings: A review of Resident 26's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. by a terrifying event). A review of Resident 26's history and physical examination [REDACTED]. A review of Resident 26's physician's orders [REDACTED]. A review of Resident 26's physician's orders [REDACTED]. A review of Resident 26's Medication Administration Record [REDACTED]. A review of Resident 26's MAR for the month of March 2020 indicated licensed vocational nurses administered [MEDICATION NAME] 10 mg at 9:00 p.m. on 3/6/20, 3/7/20, and 3/8/20. A review of Resident 26's medical records indicated no documentation of non-pharmalogical measures taken prior to the initiation of [MEDICATION NAME]. During an interview on [DATE] at 11:09 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 confirmed Resident 26 had no episodes of [MEDICAL CONDITION] manifested by inability to sleep in the month of March 2020. When asked why [MEDICATION NAME] was prescribed if the Resident had no episodes of [MEDICAL CONDITION] documented in the month of March, LVN 5 could not provide a definitive answer. When asked how nurses were quantifying [MEDICAL CONDITION] (i.e., how many hours of sleep did they consider an episode of [MEDICAL CONDITION]), LVN 5 was not able to provide an answer. LVN 5 confirmed providers would be unable to assess if the medication was effective for sleep if nurses were not documenting the hours of sleep each night. When asked what non-pharmalogical interventions were utilized prior to the initiation of [MEDICATION NAME], LVN 5 could not answer or provide any documentation regarding the interventions. When asked why it was important to start residents on non pharmalogical interventions prior to the initiation of a [MEDICAL CONDITION] medication, LVN 5 stated, Because we don't want them to be on [MEDICAL CONDITION] medications to begin with. LVN 5 confirmed [MEDICAL CONDITION] medications have several side effects that could be avoided if non pharmalogical interventions were utilized first. A review of the facility's policy dated 10/ 2017 indicated The facility should not use [MEDICAL CONDITION] medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social, or environmental cause of the resident's behaviors. Facility should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. The policy also indicated, [MEDICAL CONDITION] medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms.
F 0760 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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: 1. Administer 414 doses of [MEDICATION NAME] (a medication used to treat Human Immunodeficiency Virus (HIV - [MEDICAL CONDITION] that causes a weakened immune system)) 100 milligrams ((mg) - a unit of measure for mass) to one of 20 observed residents (Resident 61) between [DATE] and [DATE]. 2. Administer 176 doses of [MED] (an inhaled medication used to treat breathing problems) to one of 20 observed residents (Resident 45) between [DATE] and [DATE]. 3. Administer 60 doses of [MEDICATION NAME] (a medication used to treat high blood sugar) to one of 20 observed residents (Resident 7) between [DATE] and [DATE]. 4. Administer five doses of Potassium Chloride ER (a medication used to supplement low potassium levels) eight milliequivalents ((mEq) - a measure of strength for medications like potassium) to one of 20 observed residents (Resident 51) between [DATE] and [DATE]. The deficient practice of failing to administer medications in accordance with physician's orders [REDACTED]. On [DATE] at 3:30 p.m., the Department of Public Health (Department) called an Immediate Jeopardy situation (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 (ADM) and director of nursing (DON). On [DATE] at 5:48 p.m., the ADM provided the Department with a Plan of Action (POA) which included the following summarized actions: 1. Licensed staff reassessed Resident 61 and found her condition to be stable with no adverse reactions. Licensed staff

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including [MEDICATION NAME], were reordered from the pharmacy on [DATE]. Resident 61's attending physician (MD 1) ordered lab tests to further assess her condition. 2. Licensed staff reassessed Resident 45 and found her condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including [MED], were reordered from the pharmacy on [DATE]. Resident 45's attending physician (MD 1) ordered a chest radiograph (chest x-ray- imaging test that uses small amounts of [MEDICAL CONDITION] to produce pictures of the organs, tissues, and bones of the body) to further assess her condition. 3. MD 1 indicated that she would reassess Residents 45 and 61 in person on [DATE]. 4. Licensed staff performed a facility-wide, three-way medication cart audit (a check to ensure that the residents' current physician's orders [REDACTED].'s orders [REDACTED]. Upon completion of the three-way medication cart audit, licensed staff discovered medications missing for five additional residents. Licensed staff reassessed those additionally affected residents' conditions and found them to be stable with no adverse reactions. Licensed staff notified the affected residents' respective physicians of a change in status due to missing or delayed treatment. Licensed staff reported the resident's respective physicians issued no new orders as a result of the change in status reports. 6. The DON conducted an in-service (training) for all licensed staff on [DATE] at 3:00 p.m. to discuss findings and review regulations, policies, and procedures regarding availability of medications, documentation, and reordering medication from the pharmacy. 7. The director of staff development (DSD), DON, and ADM provided disciplinary action to all licensed staff found to be signing the MAR that medications were given to residents when the medications were unavailable in the facility. On [DATE] at 9:56 a.m., the Department did a facility-wide random check of medication availability. Resident 7's [MEDICATION NAME] was missing from Nursing Station 2 Medication Cart 2. On [DATE] at 12:06 p.m., in a conference meeting with the ADM and DON, the Department informed the facility that the POA was not accepted and Immediate Jeopardy was still in effect due to additional findings. On [DATE] at 11:53 a.m., the ADM provided the Department with an amended POA which included the following additional summarized actions: 1. Licensed staff reassessed Resident 7 and found her condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including [MEDICATION NAME], were reordered from the pharmacy on [DATE]. Resident 7's attending physician (MD 2) ordered lab tests to further assess her condition. 2. Licensed staff performed another facility-wide, three-way medication cart audit and found four additional residents were missing medications. Licensed staff reassessed those additionally affected residents' conditions and found them to be stable with no adverse reactions. Licensed staff notified the affected residents' respective physicians of a change in status due to missing or delayed treatment. Licensed staff reported the resident's respective physicians issued no new orders as a result of the change in status reports. 3. The DON and ADM conducted an additional in-service with all licensed staff to reiterate policies, procedures, and protocols regarding medication administration. 4. Pharmacy consultants (professionals hired to help ensure compliance with pharmacy services regulations) performed an additional three-way medication cart audit on [DATE]. On [DATE] at 10:42 a.m., the Department did a facility-wide random check of medication availability. Resident 51's potassium chloride ER 8 mEq was missing from Nursing Station 2 Medication Cart 2. On [DATE] at 1:48 p.m., in a conference meeting with the ADM and DON, the Department informed the facility that the POA was not accepted and Immediate Jeopardy was still in effect due to additional findings. On [DATE] at 7:39 a.m., the ADM provided the Department with an amended POA which included the following additional summarized actions: 1. Licensed staff reassessed Resident 51 and found his condition to be stable with no adverse reactions. Licensed staff notified the resident's attending physician regarding a change in status due to missing or delayed treatment. All medications found to be missing from the medication cart, including Potassium Chloride, were reordered from the pharmacy on [DATE]. Resident 51's attending physician ordered lab tests to further assess his condition. 2. Licensed staff performed another facility-wide three-way medication cart audit and found no additional residents were missing medications. 3. The DON and ADM conducted an additional in-service with all licensed staff to reiterate policies, procedures, and protocols regarding medication administration. On [DATE] at 11:41 a.m., while onsite and after confirming the facility's implementation of the immediate corrective actions, the Department accepted the POA and removed the Immediate Jeopardy, in the presence of the ADM and the DON. Findings: A. A review of Resident 61's admission record, dated [DATE], indicated that she was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. [REDACTED]. . A review of Resident 61's MAR between [DATE] and [DATE] indicated that a total of 654 doses of [MEDICATION NAME] 100 mg were signed as administered to Resident 61 and a total of 10 doses were documented as refused or omitted. On [DATE] at 10:05 a.m., during an interview, the medical records director (MRD) stated that he could not find any record of pharmacy delivery history for Resident 61's [MEDICATION NAME] but knows that the resident uses two different pharmacies to deliver [MEDICAL CONDITION] (Pharmacy 1 and Pharmacy 2.) On [DATE] at 10:51 a.m., during a telephone interview, the pharmacy technician (PTC 3) stated that Pharmacy 1 only had records of delivering a 15-day supply of [MEDICATION NAME] (the generic name for [MEDICATION NAME]) 100 mg for Resident 61 on [DATE]. PTC 3 stated that another order was placed on [DATE] but was not delivered due to insurance reasons. PTC 3 stated that the most recent delivery from Pharmacy 1 was made on [DATE] after the facility provided a billing authorization. PTC 3 stated that Pharmacy 1 made no other deliveries for [MEDICATION NAME] between [DATE] and [DATE]. On [DATE] at 12:33 p.m., during an observation of Nursing Station 1 Medication Cart 1, Resident 61's [MEDICATION NAME] could not be found in the medication cart. During a concurrent interview, the licensed vocational nurse (LVN 4) stated that he noticed that the [MEDICATION NAME] was unavailable in the facility yesterday and informed the resident's physician and placed a refill order with the pharmacy. LVN 4 stated that the doses scheduled for 9:00 a.m. were marked as unavailable in the [DATE] MAR on ,[DATE] and [DATE]. On [DATE] at 2:34 p.m., during a telephone interview, the registered pharmacist (RPH 2) stated that Pharmacy 2 does deliver two of Resident 61'[MEDICAL CONDITION], but has no record of making any deliveries for either her brand [MEDICATION NAME] or generic [MEDICATION NAME] tablets. A review of Resident 61's February and [DATE] MAR indicated that between ,[DATE] and [DATE], all but two doses (on ,[DATE] and [DATE]) of [MEDICATION NAME] 100 mg were signed as given. On [DATE] at 1:48 p.m., during an interview, LVN 2 stated that he has worked for this facility for approximately a month and was responsible for administering medications to Resident 61, including the 9:00 a.m. dose of [MEDICATION NAME] 100 mg, when she was on Nursing Station 2, however, her room was recently changed and she is now currently on Nursing Station 1. LVN 2 stated that he signed the MAR that several of the 9:00 a.m. doses of [MEDICATION NAME] were given in February 2020 and that his initials on the MAR indicate that the medication was actually administered to the resident. LVN 2 stated that if medications were not given for any reason, he would circle his initials and document the reason on the back of the MAR. LVN 2 denied ever signing Resident 61's MAR that [MEDICATION NAME] was administered without actually giving it to her but could not offer an explanation as to how he was giving the medication when it was unavailable in the facility. LVN 2 stated that he was unable to describe the appearance of a [MEDICATION NAME] 100 mg tablet. LVN 2 stated that if medications were unavailable, he would first check the facility's other medication carts, as residents' rooms are changed frequently, and some medications may not be transferred appropriately. LVN 2 stated that if he could not find a missing medication that way, he would notify the physician and call the pharmacy for a replacement. LVN 2 stated that sometimes he feels that it is impossible to pass medications to all of his residents in the morning within two hours and has to rely on the help of others from time to time to complete his morning medication pass. On [DATE] at 2:35 p.m., Resident 61 was observed in her room lying in her bed with her head elevated. During a concurrent interview, Resident 61 stated that she is familiar with [MEDICATION NAME] and knows it as one of [MEDICAL CONDITION]. Resident 61 stated that sometimes her medications get lost when they move her from room to room. Resident 61 stated that they have made her change rooms five times since her initial admission in [DATE]. Resident 61 stated that she was not sure if they give her the [MEDICATION NAME] 100 mg tablet or not. When shown a picture of what a [MEDICATION NAME] 100 mg tablet looks like, Resident 61 stated that she does not remember receiving any medication that looks like that. On [DATE] at 10:17 a.m., during an interview, the DON stated that Resident 61 receives her medications from two different pharmacies so it is possible that she may have received [MEDICATION NAME] 100 mg from another pharmacy, but stated that she can produce no record of delivery for [MEDICATION NAME] 100 mg from any pharmacy. DON stated that, despite the MAR being signed between [DATE] and [DATE], if it cannot be proven that any [MEDICATION NAME] 100 mg was delivered here, then the most likely explanation is that the [MEDICATION NAME] was not given to Resident 61. The DON stated that it is imperative that residents receive their medications as ordered and that Resident 61 may suffer complications from not receiving [MEDICATION NAME] which could lead to life-threatening infections likely resulting in hospitalization or death. On [DATE] at 10:34 a.m., during a telephone interview, [MEDICAL CONDITION] physician (MD 3) stated that she has

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	831 S LAKE STREET LOS ANGELES, CA 90057

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) been treating Resident 61'[MEDICAL CONDITION] she was an adolescent. MD 3 stated that if Resident 61 does not receive [MEDICAL CONDITION] as prescribed, there is big risk for [MEDICAL CONDITION] to develop resistance to her medications which would cause them not to work anymore. MD 3 stated that [MEDICATION NAME] 100 mg is especially important because it keeps another medication Resident 61 takes [MEDICAL CONDITION].[MEDICATION NAME] (a medication used to treat HIV), at an effective level in her blood. MD 3 stated that Resident 61 has developed resistance to [MEDICAL CONDITION] over her years of treatment and that [MEDICATION NAME] is one of the only fully effective medications left that she can use. MD 3 stated that if Resident 61'[MEDICAL CONDITION] develops resistance to [MEDICATION NAME], it may not be possible to fully treat [MEDICAL CONDITION] the future. MD 3 stated that if Resident 61'[MEDICAL CONDITION] not fully treated, there is a risk that she may develop life-threatening opportunistic infections (infections that occur in people with weak immune systems) which could lead to hospitalization or death. MD 3 stated that if Resident 61'[MEDICAL CONDITION] not fully treated, she may also become more likely to spread [MEDICAL CONDITION] to others. MD 3 stated that she is concerned that Resident 61 has not been receiving her [MEDICATION NAME] as documented in her MAR and thought that the resident living in a skilled nursing facility would help to increase her compliance with her medications to ensure that the medications work in the future. MD 3 stated that she relies heavily on the information in the MAR to inform her treatment decisions and even has her patients bring their MAR with them to their appointments for review. MD 3 stated that she trusts that the medications are being given as they are documented and if the medications were not actually given it may cause her to make incorrect treatment decisions that could put the resident at further risk of harm due to adverse effects (unwanted side effects of medications) of medication doses that are higher than necessary or other unnecessary medications. On [DATE] at 7:50 a.m., during an interview, the ADM stated that he was able to find many other delivery records for [MEDICATION NAME] for Resident 61 and provided additional pharmacy delivery receipts from Pharmacy 1. A review of Pharmacy 1's delivery receipts indicated that a 15-day supply (30 tablets) of [MEDICATION NAME] 100 mg was delivered to the facility for Resident 61 on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. On [DATE] at 8:27 a.m., during a telephone interview, PTC 4 stated that Pharmacy 1 delivered a 15-day supply of the generic [MEDICATION NAME] 100 mg tablets on [DATE] and confirmed that a 15-day supply of the brand [MEDICATION NAME] 100 mg tablets was delivered on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], [DATE], and [DATE] for Resident 61. PTC 4 stated that the delivery history given earlier by PTC 3 was for the generic [MEDICATION NAME] only and was under a different prescription number than the brand [MEDICATION NAME]. PTC 4 stated that the eight deliveries Pharmacy 1 made on the dates listed above constitute the entirety of the generic [MEDICATION NAME] or brand [MEDICATION NAME] that was delivered to the facility for Resident 61 and was equal to 120 total days of supply or 240 tablets. PTC 4 stated that, initially, Resident 61 was prescribed the generic [MEDICATION NAME] 100 mg tablets, but her insurance only covered the brand [MEDICATION NAME] and thus was later changed. A review of Resident 61's Resident Census List, dated [DATE], indicated that between [DATE] and [DATE], she was out of the facility for one day ([DATE]) due to a hospital visit. A review of Resident 61's MAR indicated that the facility signed a total of 654 total doses of [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets as administered between [DATE] and [DATE], however, only 240 totals doses were delivered, leaving a total deficit of 414 doses that were signed as given, but unavailable in the facility. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets in any of the facility's emergency kits (kits containing medications for emergency use) or in facility medication supply. RN 1 stated that any medications like that would only be ordered pursuant to a physician's orders [REDACTED]. On [DATE] at 1:13 p.m., during an interview, the DON stated that she agrees that the Resident 61's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MEDICATION NAME] were given when they could not have been. The DON stated that she has been unable to establish that enough [MEDICATION NAME] was ordered to cover the doses signed for. The DON stated that she understands the seriousness of this situation and stated that she wishes the other nurses realized that they are dealing with a human life and that not giving the residents their medications as ordered can kill them. On [DATE] at 3:34 p.m., during an interview, the DON stated that, after searching thoroughly and contacting each pharmacy individually, she was unable to obtain any additional records of delivery for Resident 61's [MEDICATION NAME] or [MEDICATION NAME] 100 mg tablets. B. A review of Resident 45's admission record, dated [DATE], indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 45's physician order, dated [DATE], indicated that she was prescribed [MED] HFA to use two puffs by mouth four times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. On [DATE] at 10:40 a.m., during an observation of Nursing Station 2 Medication Cart 3, Resident 45's [MED] could not be found in the medication cart. A review of Resident 45's [DATE] MAR, indicated [MED] was last administered to Resident 45 on [DATE] at 9:00 a.m. During a concurrent interview, LVN 11 stated that she was unable to find the [MED] in the medication cart or anywhere else in the facility. LVN 11 stated that she signed the MAR that she gave Resident 45 her dose of [MED] this morning at 9:00 a.m. even though it was not in available in the medication cart. LVN 11 stated that she should have circled the dose to indicate that it was unavailable but forgot to do so. A review of Resident 45's MAR indicated that a total of 276 doses of [MED] were signed as given between [DATE] and 9:00 a.m. on [DATE]. On [DATE] at 9:20 a.m., during an interview, the DON stated that Pharmacy 1 was the only pharmacy the facility used to supply Resident 45's medications. On [DATE] at 9:24 a.m., during an interview, PTC 1 stated that Pharmacy 1 delivered a 25-day supply of [MED] (one inhaler containing 200 puffs) for Resident 45 on [DATE]. PTC 1 stated that Pharmacy 1 made no other deliveries of this medication for Resident 45. A review of Resident 45's MAR between [DATE] and 9:00 a.m. on [DATE] indicated that as the pharmacy only supplied a 25-day supply, the facility would have only had enough medication to administer [MED] as documented through [DATE]. From [DATE] through 9:00 a.m. on [DATE] a total of 176 additional doses were signed as given (1 omitted) even though the medication was unavailable in the facility. On [DATE] at 10:25 a.m., during an interview, Resident 45 stated that her licensed nurse offered her the [MED] inhaler this morning, but she refused it because she was not familiar with it. Resident 45 stated that she doesn't remember receiving any of that medication since she last came back from the hospital in late [DATE]. On [DATE] at 10:39 a.m., the DON stated that she could not explain how 176 doses of [MED] were signed for when the medication was unavailable in the facility. The DON stated that she would have to ask the nurses what happened. The DON stated that the inhaler could have been saved from before Resident 45's last hospital admission even though she knows that they are not supposed to do that. On [DATE] at 11:11 a.m., during a telephone interview, PTC 2 stated that Pharmacy 1 has never delivered any [MED] for Resident 45 prior to [DATE]. On [DATE] at 11:13 a.m., during an interview, MD 1 stated that although the omission of [MED] for Resident 45 may not itself have a life-threatening clinical impact, if the medication was omitted for other residents with certain breathing problems it could be life-threatening. MD 1 stated that she is concerned that medications are not being given in the facility as recorded in the MAR and that she relies on the accurate reporting in the MAR to make informed treatment decisions. MD 1 stated that without and accurate record of what medications were given at their current doses, that she may make incorrect treatment decisions to start or stop medications or to increase or decrease their doses which could cause health complications due to adverse effects of medications. On [DATE] at 1:21 p.m., during an interview, LVN 9 stated that she is responsible for administering medications to Resident 45 in the morning. LVN 9 stated she is familiar with [MED] and confirmed that her initials were on many 9:00 a.m. and 1:00 p.m. doses of [MED] for Resident 45 in the February 2020 MAR. LVN 9 stated that her initials on the MAR indicate that the medication was given. LVN 9 stated that if not given for any reason, she would circle the dose and provide a written explanation on the back. When informed that there was not enough [MED] ordered for Resident 45 to last beyond [DATE], LVN 9 stated that she may have signed doses of [MED] on the MAR without giving them. LVN stated that sometimes she is in a hurry and may have skipped the medications that take a longer time to administer, like breathing treatments. LVN 9 stated that it is possible that she forgot to go back to indicate that the doses were not given, but that it is unlikely since there are so many doses signed for. LVN 9 stated that she has a total of 34 residents to administer medication to and feels like it is difficult to complete in a two-hour period. LVN 9 stated that she tries her best, but sometimes it takes longer because some residents are more difficult than others and require more time. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MED] in any of the facility's emergency kits (kits containing medications for emergency use) or in facility medication supply. RN 1 stated that any medication like that would only be ordered pursuant to a physician's orders [REDACTED]. On [DATE] at 2:48 p.m., during an interview, LVN 11 stated that she failed to indicate on the MAR that the 9:00 a.m. dose of [MED] on [DATE] was not given because she was distracted by the immediate needs of another resident. LVN 11 stated that she should have gone back and circled her initials on that date because the [MED] was not available. LVN 11 states that she understands that her initials on the MAR for a dose indicates that the medication was given. LVN 11

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) acknowledges that her initials are on many other doses in the February 2020 MAR and stated that I do remember giving her the inhaler. LVN 11 denied signing the MAR that the medication was given without actually giving it, but was unable to offer an explanation as to how she administered the inhaler when the resident's supply would have been exhausted by [DATE] or why the resident did not remember receiving it. LVN 11 stated this facility is so disorganized, sometimes medications are missing from the cart due to room changes, and you have to go to the other carts to try to find them. On [DATE] at 1:13 p.m., during an interview, the DON stated that there are no other pharmacy delivery records available for Resident 45's [MED] and confirmed that Pharmacy 1 is the only pharmacy used to supply her medications. The DON agrees that the Resident 45's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MED] were given when they could not have been. The DON stated that she understands the seriousness of this situation and stated that she wishes the other nurses realized that they are dealing with a human life and that not giving the residents their medications as ordered can kill them. C. A review of Resident 7's admission record, dated [DATE], indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) A review of Resident 7's physician's orders [REDACTED].) to inject 20 units subcutaneously (under the skin) every night at bedtime (scheduled for 9:00 p.m.) A review of Resident 7's MAR from [DATE] to [DATE] indicated that 56 doses of [MEDICATION NAME] were signed as administered. A review of Resident 7's MAR from [DATE] indicated that pages 2 and 3 (containing information regarding [MEDICATION NAME] administration in [DATE]) were missing. A review of Resident 7's MAR from [DATE] to [DATE] indicated that 33 doses of [MEDICATION NAME] were signed as administered. On [DATE] at 9:56 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 7's [MEDICATION NAME] could not be found in the medication cart. On [DATE] at 10:33 a.m., during an interview, LVN 2 stated that he could not find Resident 7's [MEDICATION NAME] in the medication cart, the medication storage room, or anywhere else in the facility. A review of Resident 7's pharmacy delivery records indicated Pharmacy 1 delivered one 10 ml vial of [MEDICATION NAME] on [DATE]. On [DATE] at 8:23 a.m., during a telephone interview, the registered pharmacist (RPH 1) confirmed that Pharmacy 1 only delivered one vial of [MEDICATION NAME] for Resident 7 on [DATE]. RPH 1 stated that Pharmacy 1 did not deliver [MEDICATION NAME] for Resident 7 on any other dates. RPH 1 stated that one 10 ml vial of [MEDICATION NAME] is considered a 28-day supply since, per the manufacturer's instructions, it must be used or discarded within 28 days of its first use. A review of Resident 7's MAR indicated that, after [DATE], the [MEDICATION NAME] that Pharmacy 1 had initially supplied would have been expired, however, excluding [DATE] (for which the MAR is unavailable for [MEDICATION NAME]), 60 doses of [MEDICATION NAME] were signed as given between [DATE] and [DATE]. On [DATE] at 9:36 a.m., during a telephone interview, MD 2 stated that he is the attending physician for Resident 7. MD 2 stated that it is imperative that Resident 7 receive her [MEDICATION NAME] as ordered to avoid complication of diabetes. When informed that Resident 7 may have missed several doses of [MEDICATION NAME] even though the MAR was signed indicating those doses were given, MD 2 stated That's wrong. That's so wrong. MD 2 stated that without the [MEDICATION NAME], the resident may experience uncontrolled diabetes which could cause serious health complications resulting in hospitalization or death. MD 2 stated that he would order additional lab tests to assess Resident 7's condition and come by this weekend to reassess her condition personally as her blood sugars have been elevated for several weeks. MD 2 stated that he relies on accurate information from the nursing staff as to what medications were given at the currently prescribed doses in order to guide his treatment decisions. If the medication was not actually given, he would possibly order a higher dose of [MED] than the resident needed leading to complications such as [DIAGNOSES REDACTED] (low blood sugar) that may result in coma or death. On [DATE] at 10:17 a.m., during an interview, the DON agreed that it would have been impossible for Resident 7 to have received her [MEDICATION NAME] after [DATE] since it would have expired 28 days after the initial delivery from Pharmacy 1 on [DATE]. The DON stated that there is no record of any other deliveries for it and Pharmacy 1 is the only pharmacy that supplies medications for Resident 7. The DON stated that it is imperative that residents receive their medications as ordered and that Resident 7 may suffer complications from not receiving her medications as ordered possibly leading to life threatening complications that could result in hospitalization or death. On [DATE] at 10:07 a.m., during an interview, the registered nurse supervisor (RN 1) stated that the facility does not keep [MEDICATION NAME] in any of the facility's emergency kits or in facility medication supply. RN 1 stated that any medication like that would only be ordered pursuant to a physician's orders [REDACTED]. On [DATE] at 1:13 p.m., during an interview, the DON agreed that the Resident 7's MAR does not reflect the care actually provided to her and that the most reasonable explanation is that the facility's licensed nursing staff signed the MAR that several doses of [MEDICATION NAME] were given when they could not have been. On [DATE] at 3:13 p.m., during an interview, LVN 10 stated that she administers [MED] to Resident 7 and is familiar with [MEDICATION NAME]. LVN 10 acknowledged that she signed for multiple doses of [MEDICATION NAME] for Resident 7 on the February 2020 MAR. LVN 10 stated that her initials on the MAR indicated that the medication was given. LVN 10 stated that if for any reason the medication was not given, the initials would be circled and an explanation written on the back of the MAR. LVN 10 stated that Resident 7 has three different types of [MED] and most likely what happened is that she only administered two of them, but signed for all three on the MAR. LVN 10 stated that it was possible that she signed Resident 7's MAR that the [MEDICATION NAME] was given without actually having given it to her. On [DATE] at 3:29 p.m., during an interview, the medical records director (MRD) stated that, after a thorough search, pages 2 and 3 of Resident 7's [DATE] MAR could not be found anywhere in the facility. D. A review of Resident 51's admission record, dated [DATE], indicated that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 51's physician's orders [REDACTED]. A review of Resident 51's MAR indicated that, between [DATE] and [DATE], 19 doses of potassium chloride were signed as given. On [DATE] at 10:42 a.m., during an observation of Nursing Station 2 Medication Cart 2, Resident 51's potassium chloride could not be found in the medication cart. During a concurrent interview, LVN 2 stated that he was unable to locate Resident 51's potassium chloride in the medication cart or anywhere else in the facility. A review of Resident 51's pharmacy delivery history indicated that P
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Remove one vial of [MEDICATION NAME] (a medication used to control high blood sugar) for Resident 61 and one [MEDICATION NAME] pen (an injection device containing [MEDICATION NAME]) for Resident 30 from the medication cart once they had expired in one of three inspected medication carts (Nursing Station 1 Medication Cart 1.) 2. Label one open vial of [MEDICATION NAME] for Resident 61, one [MEDICATION NAME] inhaler (a medication used to treat breathing problems) for Resident 66, and two open foil packets of [MEDICATION NAME]/[MEDICATION NAME] nebulizer solution (a medication used to treat breathing problems) for Residents 30 and 43 with an open date once open in accordance with the manufacturer's requirements in one of three inspected medication carts (Nursing Station 1 Medication Cart 1.) 3. Label one bottle of Rexulti (a medication used to treat mental illness) 2 milligram ((mg) - a unit of measure for mass) tablets for Resident 66 with a pharmacy label in accordance with currently accepted professional principles in one of three inspected medication carts (Nursing Station 1 Medication Cart 1.) 4. Store two unopened [MEDICATION NAME] pens for Residents 27 and 51 in the refrigerator or label them with a date at which room temperature storage began in accordance with the manufacturer's requirements in two of three inspected medication carts (Nursing Station 2 Medication Cart 2 and Nursing Station 2 Medication Cart 3.) 5. Store one bottle of [MEDICATION NAME] (a medication used to treat nerve pain) 250 mg/ milliliter ((ml) - a unit of measure for volume.) oral solution for Resident 91 in the refrigerator in accordance with the pharmacy labeling and the manufacturer's requirements in one of three inspected medication carts (Nursing Station 2 Medication Cart 2.) These deficient practices increased the risk that Residents 27, 30, 43, 51, 61, 66, and 91 could have received medication that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications resulting in hospitalization or death. Findings: On [DATE] at 12:33 p.m., during an observation of Nursing Station 1 Medication Cart 1, one bottle of [MEDICATION NAME] for Resident 61 was found in the medication cart labeled with an open date on [DATE]. According to the manufacturer's product labeling, [MEDICATION NAME] vials should be used or discarded within 28 days after opening. During a concurrent interview, Licensed Vocational Nurse 4 (LVN 4) stated that the [MEDICATION NAME] vial for Resident 61 with an open date on [DATE] was expired and could no longer be safely used for the resident. LVN 4 stated that it was the only vial of [MEDICATION NAME]

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) available for Resident 61 in the facility and would have to be discarded and replaced. LVN 4 stated that if a resident is given expired [MED], it may not work fully to control blood sugar which could cause health complications possibly leading to hospitalization or death. On [DATE] at 2:26 p.m., during an observation of Nursing Station 1 Medication Cart 1, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One opened vial of [MEDICATION NAME] for Resident 61 was found stored at room temperature but not labeled with an open date. According to the manufacturer's product labeling, [MEDICATION NAME] vials should be used or discarded within 28 days after opening. 2. One opened [MEDICATION NAME] inhaler for Resident 66 was found not labeled with an open date. According to the manufacturer's product labeling, [MEDICATION NAME] inhalers should be used or discarded within 12 months of opening the protective foil pack. 3. One opened foil pack of [MEDICATION NAME]/[MEDICATION NAME] nebulizer solution each for Residents 30 and 43 were found not labeled with an open date. According to the manufacturer's product labeling, vials of [MEDICATION NAME]/[MEDICATION NAME] nebulizer solution should be used or discarded within 14 days of removing from the protective foil pack. On [DATE] at 2:57 p.m., during an interview, LVN 4 stated that the above medications were either stored or labeled improperly given their manufacturer's requirements. LVN 4 stated that he would call the pharmacy to replace each of the medications above if necessary as they would not be considered safe to give to residents. LVN 4 stated that it is important to properly store and label medications so that they will work when given to the residents. LVN 4 stated that if the medications do not work as expected, the residents may experience life-threatening health complications as a result. On [DATE] at 2:14 p.m., during an observation of Nursing Station 2 Medication Cart 3, one unopened [MEDICATION NAME] pen for Resident 27 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product labeling, unopened [MEDICATION NAME] pens should be stored in the refrigerator between 36 and 46 degrees Fahrenheit (F-unit of measure of a temperature scale) and used or discarded within 28 days of opening or once they've been stored at room temperature. During a concurrent interview, Licensed Vocational Nurse 3 (LVN 3) stated that the [MEDICATION NAME] for Resident 27 was stored improperly and would need to be replaced by the pharmacy as it was uncertain how long it had been stored at room temperature. LVN 3 stated that giving [MED] to residents which has not been stored properly could cause health complications that could send them to the hospital. On [DATE] at 10:28 a.m., during an observation of Nursing Station 1 Medication Cart 1, one bottle of Rexulti 2 mg tablets was found without any kind of pharmacy label or other identifying information on it necessary to determine to which resident it belonged. During a concurrent interview, LVN 4 confirmed that bottle of Rexulti 2 mg tablets had no pharmacy label and stated that it belonged to Resident 66. When asked how he knew that when there was no pharmacy label indicating they belonged to him, LVN 4 replied everyone just knows that the Rexulti belongs to Resident 66. LVN 4 stated that it is important that medications be labeled with resident-specific information to ensure they are given to the right residents and they receive them according to the physician's orders [REDACTED]. [REDACTED]., or not labeled with an open date as required by their respective manufacturer's specifications: 1. One unopened [MEDICATION NAME] pen for Resident 51 was found stored at room temperature not labeled with a date on which room temperature storage began. According to the manufacturer's product labeling, unopened [MEDICATION NAME] pens should be stored in the refrigerator between 36 and 46 degrees Fahrenheit (F) and used or discarded within 28 days of opening or once they've been stored at room temperature. 2. One bottle of [MEDICATION NAME] 250 mg/ml oral solution for Resident 91 stored at room temperature. According to the manufacturer's product labeling and the pharmacy labeling, [MEDICATION NAME] 250 mg/ml oral solution should be stored in the refrigerator between 2 and 8 degrees Celsius (C-unit of measure on a temperature scale) or 36 to 46 degrees Fahrenheit (F). During a concurrent interview, Licensed Vocational Nurse 2 (LVN 2) stated that both Resident 51's [MEDICATION NAME] pen and Resident 91's [MEDICATION NAME] solution should have been stored in the refrigerator. LVN 2 stated that he would dispose of these medications and reorder them from the pharmacy as they were not stored properly and he could not be sure for how long they had been stored at room temperature. LVN 2 stated that it is important to store medications according to their manufacturer's requirements to make sure that they work when given to residents. LVN 2 stated that if medications do not work as expected, residents could experience health complications that could lead to hospitalization or death.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain hemoglobin (Hgb -iron containing protein that carries [MED]gen in the blood), hematocrit (Hct - blood test that measures the volume percentage of red blood cells in blood), and Hemoglobin A1C (Hgb A1C - blood test that measures your average blood sugar level for the past 2 to 3 months) tests as indicated in the physician order [REDACTED]. Findings: A review of Resident 7's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 7's initial history report completed on 11/6/19, indicated the resident has the capacity to understand and make decisions. A review of Resident 7's order summary report on 11/5/19, indicated to obtain hemoglobin and hematocrit every week on Monday. Hemoglobin A1C every 3 months on the first Monday. A review of Resident 7's physician's orders [REDACTED]. A review of Resident 7's laboratory results did not indicate the facility obtained hemoglobin A1C every 3 months as per physician order. A review of Resident 7's laboratory results indicated the facility obtained hemoglobin and hematocrit on 11/7/19, 11/26/19 and 2/28/20 instead of every Monday as per physician order. On 3/5/20 at 2:40 p.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated and confirmed Resident 7's Hgb, Hct and Hgb A1C was not obtained as per physician order [REDACTED]. On 03/05/20 at 3:21 p.m., during interview and concurrent record review, Registered Nurse 1 (RN 1) confirmed Hgb A1C blood test was not obtained since admission and Hgb and Hct test not routinely done every Monday. RN 1 stated the result of Hgb A1C played an important role to properly managed DM and will give feedback if the current [MED] medication need to be adjusted or not. On 3/6/20 at 11:29 a.m., during an interview, Director of Nursing (DON) stated laboratory order must be obtained, filed and relayed to physician for review in order to properly managed Resident 7's [MEDICAL CONDITION] and DM accordingly. A review of the facility's policy and procedures titled, Diabetes Clinical Protocol, revised 3/2015 indicated the physician will order appropriate lab tests (Hgb A1C) and adjust treatments based on these results and other parameters. A review of the facility's policy and procedure titled, [MEDICAL CONDITION] Clinical Protocol, revised 9/ 012 indicated Erythropoietin (hormone for red blood cell production) use should be based on the consideration of additional relevant factors such as the individual's prognosis, underlying causes of [MEDICAL CONDITION], and monitoring of hemoglobin/hematocrit.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow menu as written for residents on the liberal renal diet (a diet ordered by the physician for people who have kidney problems). High potassium levels can cause irregular heartbeat, muscle weakness, numbness and tingling in people with kidney problems. Residents on liberal renal diet were served high potassium food. This deficient practice had the potential to increase potassium levels in seven residents who are either on [MEDICAL TREATMENT] or have insufficient kidney function and were on liberal renal diet. Findings: According to the facility lunch menu on [DATE], the following items will be served: baked ham (3 ounces(oz-unit of measure)), raisin sauce (2 oz.), candied yams cup, seasoned peas cup, bread, margarine, oatmeal cookie and milk. During tray line and tray card observation on [DATE], at 11:45 a.m., for residents with a diet order of renal diet, the cook served candied yams cup instead of rice. During a concurrent interview with Cook 1, she stated in this facility, the residents on renal diet get the same food as residents on regular diet. She stated that the registered Dietitian had told them that everyone gets the same food. During a review of the instruction at the bottom of the menu spreadsheet, the menu indicated that liberal renal diet receives no added salt, omit foods high in potassium such as citrus, potato, banana and tomato products; and give mocha mix in place of milk. During an interview with Dietary Supervisor (DS) on [DATE], at 3:30 p.m., he stated that the liberal renal diet omits all high potassium food from the tray. He stated that the candied yams are high in potassium and should have been omitted. Renal diet should have received rice instead. DS added that the cook knows that yams are sweet potatoes and are high in potassium. He further added that Cook 1 made a mistake and did not prepare rice in advance. A review of the facility policy titled Protocol for Diet orders indicated, Liberal renal-NAS (no added salt), avoid foods high in potassium such as: Citrus, banana, Potato, Beans and tomato products. No dairy products. Give Mocha Mix in place of milk.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	831 S LAKE STREET LOS ANGELES, CA 90057

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F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 16)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety when: 1. Three large (logs) of ham and 1 large loaf of whole bologna were stored in the reach in refrigerator with no thaw (frozen to liquid state) date or use by date. 2. Nutritional supplements labeled Store Frozen with manufacturer's instruction to use within 14 days of thawing, were not monitoring for the date they were thawed to ensure expired shakes were discarded after this timeframe. 3. One staff working in the dish machine area did not wash hands when testing the sanitizer on the clean and sanitized dishes from the dish machine. 4. Sanitizer solution used to sanitize food contact surfaces such as counters and meat slicer did not have adequate amount of sanitizer. The level of the chemical used to sanitize was very high. A high concentration of sanitizer solution may be potentially hazardous and may be a chemical contaminant of food. These deficiencies had the potential to result in food borne illness in a medically vulnerable resident population of 93 who receive the food prepared by the facility and 20 residents who are on nutrition supplements at the facility. Findings: A. During an observation in the kitchen on [DATE], at 8:01 a.m. there were three logs of ham and one whole loaf of bologna stored in the reach in refrigerator to thaw. The packages had no thaw dates or use by dates. During a concurrent interview with Cook 1 on [DATE] at 8:01 a.m., she stated the ham will be used today. Cook 1 did not know when the ham was taken out of the freezer to thaw. She confirmed there was no date on it. Cook 1 then stated the bologna will be sliced and be prepared to make sandwiches. The cook did not know when the bologna was taken out of the freezer to thaw. During an interview with Dietary Supervisor (DS) on [DATE] at 3:30 p.m., DS stated that there should be a thaw date on food items to keep track of the use by dates. B. During an observation in the kitchen on [DATE] at 8:30 a.m., there was one tray of nutrition supplement shakes stored in the reach in refrigerator. There was mixture of vanilla flavored and strawberry flavored individual containers of nutritional shakes stored together on the tray. The nutritional supplement was labeled by the manufacturer with instructions to Store Frozen. The supplements were refrigerated, not frozen. There was no date to indicate when the nutritional supplements were taken out of the freezer to thaw. During a concurrent observation and interview with Cook 1 on [DATE] at 8:30 a.m., Cook 1 confirmed the nutritional supplements were in the refrigerated. Cook 1 stated that the nutrition supplements come frozen and then it is stored in the refrigerator to thaw for use. Cook 1 did not know the expiration date of the supplements. During a tour of the nursing station medicine room on [DATE] at 8:30 a.m., three vanilla flavored nutritional supplements shakes and one strawberry flavor nutritional supplement shakes were noted in the resident nourishment refrigerator, all were undated. During a concurrent interview with Nurse Supervisor (RN 1) on [DATE] at 8:30 a.m., RN 1 stated that the nutritional supplements in the refrigerator belong to residents. RN 1 stated that she did not know when the supplements were placed in the refrigerator. She further stated nurses provide the nourishments to residents and maybe the residents had refused the supplements. RN 1 stated that since there was no date on the supplements there was no way to determine how long the supplement had been in the refrigerator. During an interview with Dietary Supervisor (DS) on [DATE] at 3:30 p.m. DS stated nutritional supplement are to be kept frozen and have a shelf life of a year. DS also stated that once thawed they are ok for a month. DS agreed that there should be thaw date to monitor the 14 day thawed shelf life of the nutritional supplements. A review of the manufactures guidelines for the supplements indicated, once thawed the shakes are good for only 14 days. A review of the facility policy titled Food Storage revised 2013, indicated, All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. Date marking to indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold, or discarded will be visible on all high risk food. In addition, safe thawing: Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing. A review of the 2017 U.S. Food and Drug Administration Food Code indicated, Ready-to-eat, Time/Temperature control for safety food should be marked by date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed, sold or discarded. C. During an observation of the dish washing machine area on [DATE], at 8:32 a.m., Dishwasher (DW) was noted to be removing food particles, and then rinsing dirty dishes and loading them in the dish machine to be washed. DW was not wearing gloves. Dishwasher was asked to demonstrate dish machine operation and check sanitizer effectiveness. (DW) started the machine and walked towards the manual dishwashing sink area. DW quickly rinsed his hands in the dishwashing sink, and grabbed the sanitizer testing strips. DW did not wash hands and returned with the test strip. Once the wash and rinse cycle on the machine stopped, DW took a test strip from the container and tested the sanitizer effectiveness on the clean dish surface. The Dishwasher was touching the clean testing strips and the clean sanitized dishes. During a concurrent interview on [DATE] at 8:32 a.m. with DW, DW confirmed that he did not wash his hands after he left the soiled dishes area. He stated he rinsed his hands in the dishwashing sink and grabbed the sanitizer testing strips and checked the sanitizer effectiveness on clean dishes without washing hands. During an interview with Dietary Supervisor (DS) on [DATE] at 3:30 p.m., DS stated that DW should always wash his hands when moving from a dirty area to a clean area or changing tasks. A review of the facility policy titled Personal Hygiene training dated 2013, indicated, Wash hands in the sink designated for employee hand washing. A review of the facility policy titled Cleaning dishes/dish machine, undated, indicated that the person loading dirty dishes should not handle the clean dishes unless they change into a clean apron and wash hands thoroughly before moving from dirty to clean dishes. A review of the 2017 U.S. Food and Drug Administration Food Code, indicated the FDA has identified poor personal Hygiene including hand washing as foodborne illness risk factor. Handwashing is a critical factor in reducing pathogens that can be transmitted from hands to food or to food contact surfaces. It further indicated Food service workers should be careful not to contaminate clean and sanitized food contact-surfaces with unclean hands. D. During a tour of the kitchen on [DATE] at 8:45 a.m., a bucket full of cloth towel and sanitizer solution was stored next to the food preparation sink and meat slicer. During a concurrent interview on [DATE] at 8:45 a.m. with Cook 1, Cook 1 stated she had prepared the sanitizer solution this morning. Cook 1 stated that the sanitizer used is bleach mixed with water. Cook 1 added that the sanitizer is used to clean the meat slicer and the counters before food preparation and after. Cook 1 was asked to check the effectiveness of the sanitizer solution. Cook 1 took a test strip and immersed it in the solution in the bucket for one second and then compared the color to the test strip to the color chart. The test strip indicated a color change that showed sanitizer was not within range. The recommended concentration level for chlorine sanitizer is 50 parts per million(PPM). The test strip read was at 200 PPM. Cook 1 stated it should be between ,[DATE] PPM. Cook 1 stated she made the sanitizer solution following the directions per facility policy. She stated that she added one spoon of chlorine (bleach) to one gallon of water. Cook 1 could not find the spoon that she used to prepare the solution. When asked if she had tested the solution after preparation of the bucket, Cook 1 could not remember. During an interview with Dietary Supervisor (DS) on [DATE] at 3:30 p.m., DS stated that the instructions to prepare the sanitizer has been tested many times and the test strip results are ,[DATE] PPM. DS stated that Cook 1 must have used more than one tablespoon of bleach to add to the gallon of water. DS stated he will provide an in-service to all staff in the kitchen on how to prepare the sanitizer solution. A review of facility policy titled Towel Sanitizing Solution, undated, indicated, Use 1 tablespoon (1 capful) bleach per gallon of water. Solution should be 100 parts per million(PPM) chlorine. You must use test strips for chlorine to verify the concentration.
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** Based on observation, interviews and record reviews, the facility failed to ensure it had a policy and procedure in place for safe and sanitary storage, handling and consumption of food brought from outside the facility. This had the potential to cause food borne illness in residents in the facility who were served food brought by family, visitors or purchased outside the facility. Findings: During an interview with Registered Nurse 1 (RN 1) on 3/3/20 at 8:30 a.m., RN 1 stated that the food brought from outside for residents is stored in a refrigerator designated for the residents in the staff lounge. During a concurrent observation of the staff room with RN 1 on 3/3/20 at 8:30 a.m., RN 1 was not able to find the resident refrigerator in the staff lounge area. RN 1 later confirmed that the refrigerator had been discarded. RN 1 stated that in

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F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 17) the past no one was checking the refrigerator and resident food brought from outside was getting spoiled. She further stated resident food was thrown away often to prevent food borne illness. RN 1 did not know where to store the resident food brought from outside. She stated currently there is no refrigerator to store resident food brought from outside. RN 1 stated that the registered nurses were not responsible for monitoring the food brought from the outside for residents. During an interview with the Director of Nursing on 3/3/20 at 9;00 a.m., DON stated that the facility used to store food for residents in the resident refrigerator inside the staff lounge, but the food would spoil because no one would monitor the food. DON added that the facility decided to trash the food and the refrigerator. DON stated she did not know where to store food if presently brought from the outside fort the resident. A review of facility policy that was posted on the board in the kitchen titled, Food brought in by resident or family indicated, To prevent food borne illness. Outside food must be consumed within a reasonable time frame. Perishable food must be consumed within 2 hours. After 2 hours perishable food will be disposed. Facility does not provide refrigeration for any foods brought in by resident or family.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to include immunocompromised conditions (one who does not have the ability to respond normally to an infection due to an impaired or weakened immune system) in the facility assessment which affected nine of 98 residents who [MEDICAL CONDITION] (those having the [CONDITION] (virus that weakens immune system)). This deficient practice prevented that facility to determine resources necessary to care for its residents. Findings: During a review of the Facility's Assessment, dated 10/2019, there was no indications of residents that were affected by the Human Immunodeficiency Virus ,[MEDICAL CONDITION].. A review of the facility's [DIAGNOSES REDACTED]. During an interview on [DATE] at 2:03 p.m. with the Administrator (ADM), Director of Nurses (DON), both were asked why there was no indication [MEDICAL CONDITION] residents in the facility assessment, the ADM and DON was unable to answer.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to: 1. Include the most recent order for [MEDICATION NAME] (a medication used to treat high blood pressure) 0.2 milligrams ((mg) - a unit of measure for mass) in the medical record for one of three observed residents (Resident 27). 2. Maintain a complete record of the Medication Administration Record [REDACTED]. 3. Document one of one resident (Resident 45) refusal of RNA services in the medical record. The deficient practice of failing to maintain accurate and complete medical records for Residents 7 and 27 increased the risk that medications could have been administered incorrectly possibly causing health complications that would negatively affect their health and well-being. The deficient practice of failing to maintain accurate and complete medical records for Resident 45 had the potential to cause confusion with the care and services provided to the resident. Findings: A. Review of Resident 27's admission record, dated [DATE], indicated that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) Review of Resident 27's physician's orders [REDACTED].{SBP} - a measure of blood pressure when the heart is contracting) less than 150 millimeters of mercury ({mmHg} - a unit of measure for pressure)). On 3/4/20 at 8:50 a.m., LVN 3 was observed preparing medications for Resident 27's morning medication administration. During a concurrent interview, LVN 3 stated that Resident 27's SBP was taken earlier that morning at 7:50 a.m. and was 130 mmHg at that time. On 3/4/20 at 9:07 a.m., Resident 27 was observed taking [MEDICATION NAME] 0.2 mg and other medications provided by LVN 3 with applesauce and water. On 3/4/20 at 9:51 a.m., during an interview, LVN 3 stated that gave the [MEDICATION NAME] to Resident 27 despite the hold parameters on the MAR because he believes that the physician clarified the hold parameters and called in a more current order the last time he was readmitted to the facility following a hospital visit on 1/29/2020. LVN 3 stated that he thought that the order was not in the MAR indicated [REDACTED]. LVN stated that the medical records department may have a copy of the more current order. On 3/4/20 at 10:03 a.m., during an interview, the medical records assistant (MR 1) stated that she could not find a more recent order for [MEDICATION NAME] in Resident 27's clinical record or anywhere within the medical records room. MR 1 stated that any new order from the physician should be added to the clinical record and the MAR indicated [REDACTED]. On 3/4/20 at 1:10 p.m., during an interview, MR 1 stated that she was able to find Resident 27's new order for [MEDICATION NAME] in the basement and stated that she was unsure why it was down there instead of being integrated into his clinical record and MAR. Review of Resident 27's physician's orders [REDACTED]. On 3/5/20 at 8:51 a.m., during an interview, the medical records director (MRD) stated that the facility failed to properly integrate the new order for Resident 27's [MEDICATION NAME], which specified different hold parameters, into the clinical record. The MRD stated that without this order in the clinical record or the MAR, the licensed nurses passing medications would generally have no way to know that the hold parameters for Resident 27's [MEDICATION NAME] were changed. The MRD stated that if the licensed nursing staff did not know that the hold parameters for Resident 27's [MEDICATION NAME] had changed they might have given or withheld it in a manner that was contrary to the physician's orders [REDACTED]. B. Review of Resident 7's admission record, dated 3/5/20, indicated that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].) Review of Resident 7's physician's orders [REDACTED].) to inject 20 units subcutaneously (under the skin) every night at bedtime (scheduled for 9 PM.) Review of Resident 7's MAR from January 2020 indicated that pages 2 and 3 (containing information regarding [MEDICATION NAME] administration in January 2020) were missing. On [DATE] at 3:29 p.m., during an interview, the MRD stated that, after a thorough search, pages 2 and 3 of Resident 7's January 2020 MAR indicated [REDACTED]. C. A review of the admission record indicated Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 45's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/21/20, indicated Resident 45 was cognitively intact (the process of acquiring knowledge and understanding through thought, experience, and the senses) in daily decision making skills. Resident 45 required two-person assistance with transfer and had not walked during the time of the assessment. A review of Resident 45's physician's orders [REDACTED]. Restorative Nursing Assistant (RNA) to provide Active Range of Motion (AROM- the therapist helps the patient do these exercises) to both lower extremities (legs) five days a week as tolerated. 2. RNA to provide transfer sit and stand at parallel bars (medical devices specifically used in physical and occupational rehabilitation therapy to assist individuals to re-learn to walk and for gait training) five days a week as tolerated. During an interview and concurrent record review with Restorative Nursing Assistant 1 (RNA 1) on 3/03/20 at 10:51 a.m., RNA 1 stated Resident 45 did not do her RNA treatment on 3/2/20 due to knee pain. RNA 1 stated he should have documented Resident 45's refusal. RNA 1 stated Resident 45 refuses treatment about twice a week. RNA 1 stated it has been approximately two weeks since Resident 45 performed sit to stand transfer as ordered by the physician. A review of the facility's policy and procedure titled, Charting and Documentation, revised 1/22/20, indicated all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. The policy indicated to document whether the resident refused the procedure/treatment.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observation, interview and record review, the facility failed to ensure that the Quality Assurance Performance Improvement (QAPI) committee identify and implement an action plan to ensure its residents had their prescribed medication available and administered as ordered by the physician given that a medication issue had previously been identified during a previous Immediate Jeopardy (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). This deficient practice left residents' medical conditions untreated and had the potential to affect the health and safety of the residents. Findings: During medication observation and record review conducted throughout the Recertification survey on 3/2/20 through [DATE], it was noted that multiple residents in the facility had prescribed medications unavailable and as a

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 18) results were not being administer the medications as ordered by their physicians. During an interview with the Administrator (ADM), Director of Nurses (DON) and Licensed Vocational Nurse 5 (LVN 5) on [DATE] at 2:03 p.m., the staff was asked how multiple residents continued to have issues with medication availability. ADM stated that prescribing pharmacy, consultant pharmacist, and consultant nurses are to check and verify medications, but it was clear that it was not being done adequately. ADM states that moving forward they would implement more monitoring to ensure medication availability. During a record review of the facility's Plan of Action (POA) dated 1/15/19, from the previous IJ which also involved medication issues, POA indicated any issues identified will be reported to the Administrator who will report findings monthly to the QAPI committee for review. However, there was no indication of a QAPI review to prevent missing medications issue. During a concurrent interview with the Administrator (ADM), Director of Nurses (DON) and Licensed Vocational Nurse 5 (LVN 5) on [DATE] at 2:03 p.m., the staff was asked why there was no QAPI plan for medication availability as this was a previously identified issue which resulted in a previous IJ, both the ADM and DON stated they do not have an analysis of the nurses work, and as a result could not identify prevalent pharmacy issues. LVN 5 stated that due to the current Recertification survey, they are now seeing the issues with medication and will start including the data into the QAPI binders. A review of the policy and procedure titled QAPI, at a Glance, reviewed 1/22/20, indicated that QAPI is a data driven, proactive approach to improving the quality of life, care , and services in nursing homes.
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 ensure staff practiced appropriate infection control practices for two of three sampled residents (Resident 26 and Resident 58) when: 1. Registered Nurses (RNs) did not change Resident 26's peripherally inserted central catheter (PICC-long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) dressing when the transparent (clear) dressing began peeling, did not properly place an antimicrobial dressing at the insertion site, and did not ensure the stabilization device for the PICC was covered entirely by the transparent dressing. 2. A licensed vocational nurse (LVN) did not change her gloves during Resident 58's wound care treatment after handling soiled (contaminated or dirty) gauzes (thin, loosely woven fabric) These deficient practices had the potential to cause an infection and compromise the health and well-being of both residents. Findings: A. A review of Resident 26's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to an infection). A review of Resident 26's history and physical examination [REDACTED]. A review of Resident 26's physician order [REDACTED]. A review of Resident 26's intravenous therapy care plan dated 3/3/20 indicated to change the dressing every 7 days and as needed. During a concurrent observation and interview on 3/3/20 at 9:41 a.m., Resident 26 was observed lying in bed. Resident 26 had a PICC on his right upper arm. The transparent dressing was peeling off. A small, white disc containing an antimicrobial (agent that kills bacteria, viruses, etc.) solution of [MEDICATION NAME] (an antiseptic (chemical that slows growth of germs to prevent infections) agent) was observed lying on top of the insertion site, and not surrounding the catheter. The stabilization device was partially covered with the transparent dressing. During an interview with the registered nurse (RN 1), RN 1 confirmed the transparent dressing was peeling and should have been changed per facility policy to reduce the risk of infection at the site. RN 1 also confirmed the white disc containing the antimicrobial agent was improperly placed, which would cause the agent to be less effective in preventing infections. RN 1 also confirmed the stabilization device holding the PICC in place should have been covered by the transparent dressing to prevent infections. A review of the 2018 manufacturer's guidelines for the white disc containing the antimicrobial agent indicated to position the disc around the catheter site, so the catheter rests on the slit portion of the disc. The guidelines also indicated the slit edges should come in contact with one another to ensure best efficacy. A review of the facility's policy titled PICC Dressing Change dated 6/2018 indicated dressing changes using transparent dressings are performed upon admission, at least weekly, and if the integrity of the dressing has been compromised (i.e., wet, loose, or soiled). B. A review of Resident 58's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 58's history and physical examination [REDACTED]. A review of Resident 58's physician's orders [REDACTED]. The order indicated to cleanse with normal saline (wound cleansing solution), pat dry, and apply silver [MEDICATION NAME] (topical medication used for the prevention and treatment of [REDACTED]. A review of Resident 58's physician's orders [REDACTED]. During an observation on [DATE] at 9:16 a.m., Resident 58 was observed sitting in his wheelchair with both of his legs propped onto the bed. Resident 58 was noted with a stage 4 (muscle and bone exposure) pressure ulcer (injury to the skin due to prolonged pressure) on his left heel and an open wound on his right second toe. Licensed vocational nurse 12 (LVN 12) was observed washing her hands. LVN 12 donned (put on) new gloves and removed the existing dressing on the right toe and threw the soiled dressing into a trash bag. LVN 12 then cleansed the open wound with a 4 inches x 4 inches (4x4) gauze that was soaked with normal saline and threw the soiled gauze into a trash bag. LVN 12 did not wash her hands or don new gloves after cleaning the wound. LVN 12 then opened the occlusive dressing package, cut a piece of the dressing into a small square, and placed the small square over the open wound. LVN 12 then opened a new adhesive dressing package, and was observed touching the inside of the adhesive dressing before placing it over the small square. LVN 12 dated and signed the dressing using a black permanent marker. LVN 12 was then observed removing her gloves and washing her hands again before donning new gloves. LVN 12 then wiped the left heel with a 4x4 gauze that was soaked in normal saline, and threw the soiled gauze into a trash bag. LVN 12 did not wash her hands again, and did not don a new pair of gloves before opening a new 4x4 gauze. LVN 12 placed silver [MEDICATION NAME] onto the gauze, and placed the gauze over the resident's left heel. LVN 12 then covered the gauze with a large adhesive dressing and signed and dated the dressing using a black permanent marker. During an interview with LVN 12 on [DATE] at 9:30 a.m., LVN 12 confirmed she did not wash her hands or change her gloves after cleansing each wound on the right toe and the left heel. LVN 12 confirmed it was important to change her gloves and wash her hands after touching soiled gauzes and contaminated body sites before placing a new dressing or treatment onto the wounds. LVN 12 also confirmed she should not touch the interior of a new dressing and should only touch the outside border of the dressing. LVN 12 confirmed as a result, Resident 58 could have the potential to develop wound infections. A review of the facility's policy titled Infection Control Guidelines for All Nursing Procedures revised 9/2012 indicated to wash hands or use an alcohol-based hand rub before handling clean or soiled dressings, gauze pads, and when moving from a contaminated body site to a clean body site during resident care. The policy also indicated to wash hands or use an alcohol-based hand rub after contact with a resident's intact skin and after handling used dressings.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.** Based on interview and record review, the facility failed to have a physician champion lead their antibiotic stewardship program (ASP) and did not provide physicians feedback regarding their prescribing patterns for antibiotics per facility protocol. These deficient practices could have the potential to lead to improper tracking and monitoring of antibiotic use, lack of physician guidance for antibiotic stewardship, and unnecessary prescribing of antibiotics, which could result in increased rates of antibiotic resistance. Findings: During a concurrent interview and record review with the Infection Preventionist (IP) on [DATE] at 10:44 a.m., the facility's 2016 policy for antibiotic stewardship program was reviewed with the IP. The policy indicated the facility will identify an ASP Physician Champion who is committed to supporting a facility's safe and appropriate use of antibiotics. The policy indicated, The ASP Physician Champion will communicate the facility's expectations for antibiotic use to prescribing clinicians. The policy also indicated, Feedback will be given to physicians by the ASP team on their individual prescribing patterns of cultures ordered and antibiotics prescribed, as indicated. The IP confirmed the facility did not have a dedicated ASP Physician Champion who was committed to supporting the facility's appropriate use of antibiotics or spoke with other physician's regarding expectations for antibiotic use. The IP also confirmed the facility did not provide physicians with feedback regarding their prescribing patterns for antibiotic use and culture ordering. The IP confirmed both components were important in reducing unnecessary prescription of antibiotics and to improve the implementation of their program.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer one of five sampled residents (Resident 94) the opportunity to receive a pneumococcal vaccine (prevents infection from Streptococcus (bacterium that causes one of the most common and severe forms of pneumonia)) upon admission to the facility per policy. This deficient practice resulted in lack of education and had the potential to result in pneumonia for Resident 94. Findings: A review of Resident 94's admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEVIEW TERRACE	**831 S LAKE STREET LOS ANGELES, CA 90057**

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 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 19) record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 94's history and physical examination [REDACTED]. A review of Resident 94's medical records indicated the resident was not offered the pneumococcal vaccine upon admission to the facility. During an interview with the licensed vocational nurse (LVN 1) on [DATE] at 5:45 p.m., LVN 1 stated they forgot to offer the pneumococcal vaccine to Resident 94 even though he was eligible to receive the vaccine per facility policy. LVN 1 stated the as a result, Resident 94 could be infected with pneumonia. LVN 1 stated the pneumococcal vaccine was important because it protected against pneumonia. A review of the facility's policy titled Pneumococcal Vaccine, revised 6/2019, indicated prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. Historical information is obtained and recorded if available.