| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056144 | A. BUILDING _____ B. WING _____ | 03/13/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **HUNTINGTON PARK NURSING CENTER** | **6425 MILES AVENUE HUNTINGTON PARK, CA 90255** |

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

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to develop a care plan for two of 18 residents (Resident 19 and 178). This deficient practice placed the resident at risk for lack of appropriate interventions and the potential for adverse side effects from oxygen use and risk for not receiving appropriate resident centered care. Findings: a. During an observation on 3/10/20 at 2:00 p.m., Resident 19 was observed receiving oxygen with humidification (a medical device used to provide moisture during oxygen therapy) at 3 liters per minute (LPM, unit of volume) through a nasal cannula (NC)(a device consisting of a lightweight tube which on one ends splits into two prongs which are placed in the nose and from which a mixture of air and oxygen flows). A review of Resident 19's Admission Record indicated the resident was admitted by the facility on 1/31/20 with [DIAGNOSES REDACTED].), and [MEDICAL CONDITION] (the loss of the ability to move all four limbs). A review of Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 7/24/19, indicated Resident 19 had severe cognitive (ability to think, understand and make decisions of daily living) impairment and required total dependence on activities such as positioning, transfers, bathing, and eating. A review of Resident 19's Admission Nursing assessment dated [DATE], indicated the resident was non-verbal, does not respond to verbal instructions, was bed-ridden and was resumed on oxygen therapy at 3 LPM through nasal cannula with humidification by bedside. During an interview on 3/12/20 at 9:51 a.m., with Assistant Director of Nursing (ADON) stated Resident 19 received oxygen therapy with humidification at 2 LPM through nasal cannula. A concurrent record review indicated the resident did not have a physician's (MD) order and care plan for oxygen use. The ADON stated oxygen therapy was considered a treatment. The ADON stated, the resident was at risk for unnecessary oxygen and can cause hyperventilation (excessive rate and depth of respiration leading to abnormal loss of carbon [MEDICATION NAME] from the blood).<br><br>b. A review of Resident 178's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. of urine, pruritus (skin rash), and presence of cardiac pacemaker (a device placed in the chest or abdomen to help control abnormal heart rhythms). A review of Resident 178's Care Plans initiated on 3/06/2020 were missing focus, goals or interventions related [MEDICAL CONDITION], type 2 diabetes mellitus, unspecified severe protein-calorie malnutrition, [MEDICAL CONDITIONS], localized [MEDICAL CONDITION], retention of urine, pruritus, and presence of cardiac pacemaker. During an interview and concurrent record review on 3/13/2020 at 1:42 p.m., the Director of Nursing (DON) stated the facility failed to initiate a personalized care plan that focused on the disease processes [MEDICAL CONDITION], type 2 diabetes mellitus, unspecified severe protein-calorie malnutrition, [MEDICAL CONDITIONS], localized [MEDICAL CONDITION],<br>retention of urine, pruritus, and presence of cardiac pacemaker for Resident 178. The DON stated not having care planned for all the admitting [DIAGNOSES REDACTED]. A review of the facility's policy dated in 2008, titled Care Plan, Comprehensive, indicated the facility was to develop, in conjunction with the resident and/or representative, the Comprehensive Resident Care Plan. The care plan is directed toward achieving and maintain optimal status of health, functional ability, and quality of life. It is completed no later than seven (7) days after the completion of the Resident Assessment Instrument (RAI, helps the facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan). The resident plan of care is reviewed within 21 days after admission and quarterly at the minimum thereafter. |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure nursing staff would be able to assemble an injection kit to administer a medication for one (1) of 18 sampled residents (Resident 378) and failed to follow up with other medical providers, and/or responsible party, when Resident 378 ran out of medication to treat [MEDICAL CONDITION] (a disabling disease of the brain and spinal cord that can cause permanent damage or deterioration of the nerves). These deficient practices resulted in Resident 378 not receiving the medication as ordered by the physician on five occasions within a two-week period and had the potential for medication errors, continued missed doses, and delay in treatment to meet the needs of the resident. Findings: During a medication administration observation on 3/11/20 at 10:09 AM, a licensed vocational nurse (LVN 1) was preparing an injectable medication for Resident 378. The medication was Extavia (brand name for interferon beta-1b, a medication to reduce flare-ups of [MEDICAL CONDITION]) 0.3 milligram (mg) injection kit. The kit came with a vial containing the medication in powder form and a syringe prefilled with the [MEDICATION NAME]. At 10:15 a.m, LVN 1 was not able to introduce the [MEDICATION NAME] in the prefilled syringe into the vial, and failed to reconstitute the medication. LVN 1 proceeded to ask a registered nurse (RN 1) for assistance. RN 1 decided to check with the pharmacy. The pharmacy indicated they did not provide the medication and instructed RN 1 to contact the prescribing doctor and/or the manufacturer for instructions. A review of Resident 378's Admission Record indicated Resident 378 was admitted on [DATE] including [MEDICAL CONDITION]. A review of Resident 378's electronic medication order indicated a physician order dated on 2/25/20 at 9:31 p.m. for Extavia 0.3 mg kit to be injected subcutaneously (under the skin) one time a day, every other day for [MEDICAL CONDITION]. A review of Resident 378's electronic Medication Administration Record [REDACTED]. There were 5<br>out of those 8 doses that were marked as medication not available. A review of the facility policy last revised 1/1/13 titled General Dose Preparation and Medication Administration indicated the facility staff shall comply with facility policy, applicable law and State Operations Manual (SOM) when administering medications, |
| F 0679<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide activities to meet all resident's needs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to provide activities, or regular room visits, and an ongoing program to support the resident in his choice of activities for one of 18 sampled residents (Resident 14). This deficient practice had the potential for feelings of isolation and to psychosocial harm. Findings: During an interview on 3/11/20 at 10:26 a.m., Resident 14 stated no one has come to his room for room visits for a long time. Resident 14 stated the activities staff used to come and visit but no longer comes for room visits. Resident 14 stated he would very much like to participate in activities and receive room visits. Resident 14 stated the situation makes him feel isolated and lonely.<br>A review of the admission record indicated Resident 14 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the minimum data set (MDS) a standardized assessment and care screening tool dated 12/14/19, indicated Resident 14 had moderate cognitive (ability to make decisions of daily living) impairment and required one to two-person physical assistance in activities of daily living (ADL) such as getting dressed, personal hygiene and transferring from bed to wheelchair or back to bed. Further review of the MDS indicated doing things with groups and going outside to get fresh air when the weather |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0679<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>was good were important to the resident. A review of Resident 14's medical record indicated a physician's (MD) order dated 12/9/16 indicating Resident 14 may participate in activities reviewed and approved when not in conflict with the treatment plan. During an interview on 3/12/20 at 4:29 p.m., the activities director (AD) stated dependent residents get room visits two to three times a week, preferably everyday when possible. The AD stated during a concurrent record review, from 12/1/19 through 3/1/20, a period of 14 weeks, Resident 14 had nine room visits in total. The AD stated the resident should have had at least 28 room visits. The AD stated room visits were important because they provide residents with socialization and human contact. A review of the facility policy titled Individual & Room Visit Programs, dated 2015 indicated the facility was to provide adequate activity and contact opportunities to those residents who are unable to leave, or who choose to stay primarily in their own rooms. |
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview the facility failed to ensure a pressure ulcer (injury to the skin and underlying tissue due to prolonged pressure), was not left without a dressing and kept clean and dry for one of 18 residents (Resident 25). This deficient practice had the potential to slow down wound healing and/or worsen Resident 18's pressure ulcer. Findings: During an observation of a wound dressing change with licensed vocational nurse (LVN 4) on 3/12/20 at 11:00 a.m., there was no dressing on Resident 25's sacral (bony area at the base of the spine) pressure ulcer. A review of the admission record indicated Resident 25 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the minimum data set (MDS), a standardized care and assessment tool dated 1/12/20 indicated Resident 25 had severe cognitive (ability to make decisions of daily living) impairment and required one to two-person assistance with activities of daily living (ADLs) such as getting dressed, toileting, personal hygiene and bed mobility (moving from side to side, turning while in bed). A review of Resident 25's medical record of a wound assessment indicated the size of the wound was 2.8 centimeters (c.m.) long X 2.6 c.m. wide X 0.9 c.m. deep, and a physician's (MD) order dated 2/19/20 to apply treatment, to cover wound with a bordered gauze, and to replace the dressing as needed. During an interview on 3/12/20 at 11:54 a.m., LVN 4 stated since the wound was uncovered it could have been exposed to fecal matter, or urine causing it to get infected, and worsen. According to the National Institute of Health, NIH (a governmental health research agency), pressure ulcer dressings are a crucial part of healing. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 48/pdf/bmj 472.pdf) |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure an accurate assessment was conducted for one of 18 sampled residents (Resident 19). This deficient practice resulted in the inaccuracy of the resident's respiratory status. Findings: During an observation on 3/10/20, at 2:00 p.m., Resident 19 was observed receiving oxygen with humidification (a medical device used to provide long-[MEDICATION NAME] moisture during oxygen therapy) at 3 liters per minute (LPM, unit of volume) through a nasal cannula (NC, a device consists of a lightweight tube which on one ends splits into two prongs which are placed in the nose and from which a mixture of air and oxygen flows). A review of Resident 19's admission record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].), and [MEDICAL CONDITION] (the loss of the ability to move all four limbs). A review of Minimum Data Set (MDS), a standardized assessment and care screening tool dated 7/24/19, indicated Resident 19 had severe cognitive (ability to make decisions of daily living) impairment with daily decision making and required total dependence on activities such as positioning, transfers, bathing, and eating. A review of Resident 19's Admission Nursing Assessment, dated 3/8/20, indicated, the resident was non-verbal, does not respond to verbal instructions, and was bed-ridden. A review of Resident 19's Admission Notes dated 3/8/20, indicated the resident currently was receiving oxygen at 3 LPM through a nasal cannula with humidifier. During an interview on 3/12/20, at 9:38 a.m., with licensed vocational nurse 5 (LVN 5) indicated, residents receiving oxygen therapy needed a physician's orders [REDACTED]. [REDACTED]. The ADON stated the resident was at risk for unnecessary oxygen and can cause hyperventilation (excessive rate and depth of respiration leading to abnormal loss of carbon [MEDICATION NAME] from the blood). A review of the facility's policy dated 8/2014, titled Oxygen Administration, indicated to check physician's orders [REDACTED]. Set the flow meter to the rate ordered by the physician. Precaution: constant flow of oxygen can cause drying and thickening of normal secretions resulting in laryngeal ulceration. |
| F 0698<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Past noncompliance - remedy proposed**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure that facility nursing staff had immediate access to emergency treatment equipment for two of 18 residents (Resident 71 and 179) who were receiving [MEDICAL TREATMENT] (process of filtering wastes, salts and fluid from the blood when the kidneys no longer work adequately). This deficient practice placed the residents at risk for injury and/or death related to inadequate emergency interventions in the case of arterioventricular (AV) shunt (passage which moves, or allows movement of, fluid from one part of the body to another) or perma catheter (a special IV line into the blood vessel) bleeding. Findings: a. During an observaiton on 3/13/2020 at 8:36a.m., there was no emergency [MEDICAL TREATMENT] equipment at Resident 179's bedside. A review of Resident 179's Admission Record indicated the resident was admitted by the facility on 3/02/2020. Resident 179's admitting [DIAGNOSES REDACTED]. Data Set ((MDS) dated [DATE], indicated the resident had an active [DIAGNOSES REDACTED]. During observation on 3/13/2020 at 9:41a.m., there was no emergency [MEDICAL TREATMENT] equipment at Resident 71's bedside. A review of Resident 71's Admission Record, indicatedthe resident was admitted by the facility on 2/19/2020. Resident 71's admitting [DIAGNOSES REDACTED]. A review of Resident 71's Minimum Data Set ((MDS) dated [DATE], indicated the resident had an active [DIAGNOSES REDACTED]. During an interview on 3/13/2020 at 8:46 a.m., licensed vocational nurse (LVN 2) stated there was no [MEDICAL TREATMENT] emergency kit at Resident 179's bedside. LVN 2 stated the [MEDICAL TREATMENT] emergency kit was usually placed at the resident's bedside but could not be found. LVN 2 was unable to verbalize where the emergency equipment could be obtained in case of [MEDICAL TREATMENT] bleeding. LVN 2 stated the [MEDICAL TREATMENT] emergency kits should have been checked during morning rounds. During an interview on 3/13/2020 at 1:32 p.m., the Director of Nursing (DON) stated the facility [MEDICAL TREATMENT] emergency kits are placed at the resident's bedside in case of a bleeding emergency. The DON stated not having the equipment at resident's bedside placed the [MEDICAL TREATMENT] residents at increased risk for injury and/or death during an emergency with a [MEDICAL TREATMENT] bleeding . |
| F 0726<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **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.**<br><br>Based on interview, and record review the facility failed to ensure that all certified nursing and licensed nursing staff were assessed for skill competency annually. This deficient practice had the potential for risk for injury related to incompetent nursing staff skills. Findings: During record review of employee files with the Director of Staff Development (DSD) on 3/13/2020, it was noted that six of six sampled facility employees did not receive skill competencies annually as follows: Employee 5 (Certified Nurses Assistant) date of hire 9/11/2018 Employee 6 (Certified Nurses Assistant) date of hire 8/30/2018 During an interview on 3/13/2020 at 10:30a.m., the Director of Staff Development (DSD) reviewed employee files and stated that she had only worked the as the DSD for the facility for only a short time and was unaware of the reason the nursing staff did not have competencies. The DSD stated the failure to perform nursing competencies placed the residents at risk for injury due to lack of nursing skills. |
| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the physician (MD) and follow up on a medication to treat [MEDICAL CONDITION] (a disabling disease of the brain and spinal cord that can cause permanent damage or deterioration of the nerves), which required special handling for one of 18 residents (Resident 378). These deficient practices resulted in Resident 378 not receiving the medication as ordered by the physician on five occasions within a two-week period and had the potential for delay in treatment to meet the needs of the |

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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>resident. Findings: During a medication administration observation on 3/11/20 at 10:09 AM, a licensed vocational nurse (LVN 1) prepared an injectable medication for Resident 378. The medication was Extavia (brand name for interferon beta-1b, a medication to reduce flare-ups of [MEDICAL CONDITION]) 0.3 milligram (mg) injection kit. A review of Resident 378's Admission Record indicated Resident 378 was admitted on [DATE] includng [MEDICAL CONDITION]. A review of Resident 378's electronic medication order indicated a physician order [REDACTED]. Medication Administration Record [REDACTED]. The eMAR<br>indicated there were four doses (on 2/28/20, 3/5/20, 3/7/20, and [DATE]) which were marked as medication not available and one dose (on 3/3/20) that was blank and had no documentation indicating whether or not it was given. There was one dose on 3/11/20 that was not administered due to technical issue during the preparation for administration (Refer to F658). During an interview on 3/11/20 at 2:31 p.m. , Resident 378 indicated the Extavia had a special ordering process that the prescribing doctor had to make a special order for the manufacturer to drop the shipment at the resident's home. The resident indicated the resident's family member usually picked up Extavia and dropped off at the facility. The resident stated he was aware of the missed doses and indicated LVN 1 had informed the resident of the medication preparation issue that occurred early in the morning. Resident 378 stated he has requested a family member to bring another kit to the facility. Resident 378 stated the medication gives him more energy. During an interview and concurrent record review on 3/11/20 at 4:41 p.m, the director of nursing (DON) stated there was no additional documentation for the five doses that were not given; there was no documentation that nurses had communicated with the doctors, or followed up on the availability of medication. The DON indicated the facility could make better arrangements to coordinate Resident 378's special medication needs with the resident's MD, family, and pharmacy. |
| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure [MEDICATION NAME] (a [MEDICAL CONDITION] medication<br>that acts on the brain and nerves to produce a calming effect) prescribed as needed (PRN) was limited to 14 days. This deficient practice placed the resident at risk for receiving unnecessary [MEDICAL CONDITION] medication which can lead to adverse side effects. Findings: A review of Resident 7's Admission Record indicated the resident was admitted by the facility on 5/14/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care<br>screening tool, dated 12/11/19 indicated Resident 7 had moderate cognitive impairment (ability to think, understand, and make daily decisions). During a review of physician (MD) orders dated on 9/1019, Resident 7 had an order for [REDACTED]. A review of the MRR dated 10/30/19 through 11/24/19 indicated a repeat recommendation to discontinue [MEDICATION NAME] 1 mg<br>tablet by mouth every six hours as needed for anxiety. The MMR's indicted that if this medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. During an interview on 3/12/20 at 3:11 p.m., with licensed vocational nurse (LVN 5) stated Resident 7 has been taking [MEDICATION NAME] as needed since 9/10/19, and was unable to determine the stop date of the medication. A review of Resident 7's Medication Administration Record [REDACTED]. On 9/2019, the resident received 9 doses of PRN [MEDICATION NAME] medication. 2. On 10/2019, the resident received 18 doses of PRN [MEDICATION NAME] medication. 3. On 11/2019, the resident received 16 doses of PRN [MEDICATION NAME] medication. 4. On<br>12/2019, the resident received 11 doses of PRN [MEDICATION NAME] medication. 5. On 1/2020, the resident received 28 doses of PRN [MEDICATION NAME] medication. 6. On 2/2020, the resident received 9 doses of PRN [MEDICATION NAME] medication.<br>During an interview and concurrent record review on 3/12/20 at 3:23 p.m., the Assistant Director of Nursing (ADON) stated Resident 7's start date of [MEDICATION NAME] 1 mg tablet by mouth as needed every 6 hours was on 9/10/19, and stated there was no stop date on the order. During an interview on 3/13/20 at 8:48 a.m., the Director of Nursing (DON) stated that [MEDICATION NAME] 1 mg tablet by mouth as needed every 6 hours order was missing the duration date. The DON indicated during 1/2019 through 10/2019 it was the responsibility of the ADON to follow up with the pharmacist's monthly medication review (MMR). The DON stated that there was no follow-up with the physician on the pharmacist's MMR for the months of 8/2019 through 10/2019 to discontinue [MEDICATION NAME] 1 mg tablet by mouth every 6 hours as needed for anxiety on 9/24/19. A review of the facility's policy dated 11/2017, titled [MEDICAL CONDITION] Medication Management, indicated clinically necessary PRN [MEDICAL CONDITION] drug orders are limited to 14 days. If the prescribing practitioner determines a need for continued PRN use beyond the original 14 days, it is accompanied by supporting documentation in the electronic health record (EHR) including the rationale for continued use and duration. |
| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure two of 18 sampled residents (Resident 77 and 378) were free of significant medication errors, as evidenced by: 1. For Resident 77, the facility failed to document two doses of intravenous (IV) antibiotic medications (to treat certain systemic infection) were administered, on 3/1/20 and 3/4/20. The facility failed to document the reason for at least 1 dose of the IV antibiotic medications on 2/29/20 that was not administered and failed to follow up on a refused dose on 3/4/20. 2. For Resident 378, the facility failed to document the resident's blood pressure (BP) measurements which were required for the two of the resident's medications to treat high blood pressure (carvedilol and [MEDICATION NAME]). The facility failed to document the reasons why at least five doses were not administered within a two-week period (2/25/20 through 3/11/2020). These deficient practice of omission of medications had the potential for significant medication error and an increased risk of adverse consequences that may affect residents' health conditions. Findings: 1. Review of Resident 77's admission record indicated Resident 77 was re-admitted on [DATE] [MEDICAL CONDITION] (a potentially life-threatening condition caused by body's response to an infection) due to [MEDICAL CONDITION] (MRSA, a strain of bacteria that causes life-threatening infection). A review of Resident 77's electronic medication order indicated a physician (MD) order dated on 2/28/20 at 8:38 p.m. of [MEDICATION NAME]-tazobactam (a type of antibiotic that treat certain infection) 3.375 gram (gm) intravenously every 8 hours [MEDICAL CONDITION] due to urinary tract infection, for 7 days, which equaled to 21 doses in total. On 3/11/20 at 4:01 p.m., during an inspection of the IV cart (cart containing supplies for the administration of IV medications) with a registered nurse (RN 1), there were 4 IV [MEDICATION NAME]- tazobactam medications labeled for Resident 77's in the drawer. RN 1 stated Resident 77's antibiotic therapy with [MEDICATION NAME]-tazobactam ended on 3/6/20. RN 1 could not answer why there were 4 doses of Resident 77's IV [MEDICATION NAME]-tazobactam remaining in the IV cart. A concurrent record review of Resident 77's electronic medication administration record (eMAR) indicated there were 2 blank spaces for the doses on 3/1/20 at 7 a.m. and on 3/4/20 at 7 a.m. RN 1 indicated those blank spaces in the eMAR meant the medication administration was not charted or not given. A further review of Resident 77's eMAR indicated one dose on 2/29/20 at 7 a.m. was documented as 5 (Hold / See progress note) and one dose on 3/4/20 at 3 p.m. was documented as 2 (drug refused). However, after a concurrent review of Resident 77's progress notes, RN 1 confirmed there was no documentation of the reason to hold the dose on 2/29/20. There was also no documented follow up documentation on the refused dose on 3/4/20. During an interview on 3/12/20 at 9:29 a.m., the director of nursing (DON) stated Resident 77's therapy of [MEDICATION NAME]-tazobactam was not completed if there were four doses remaining at the end of the 7-day course of therapy. The DON indicated incomplete antibiotic therapy could result in unresolved infection. A review of the delivery receipts retrieved from the pharmacy indicated that the pharmacy delivered 21 doses. During an interview on 3/12/20 at 9:45 a.m., the DON stated there was a potential the aforementioned doses were not actually administered, or omitted. 2. Review of Resident 378's admission record indicated Resident 378 was admitted on [DATE] including [MEDICAL CONDITION] (a disabling disease of the brain and spinal cord that can cause permanent damage or deterioration of the nerves) and [MEDICAL CONDITION] pectoris (a medical term for chest pain or discomfort due to coronary [MEDICAL CONDITION]). A review of Resident 378's electronic medication orders indicated a physician order [REDACTED]. [REDACTED]. During a review of Resident 378's eMAR and a concurrent interview on 3/11/20 at 3:25 p.m., a licensed vocational nurse (LVN 1) stated there were at least two doses (on 3/3/20 and 3/5/20) for [MEDICATION NAME] was not documented as given, and three doses (3/3/20, 3/5/20, and 3/6/20) for carvedilol was not documented as given. During a |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>concurrent review of Resident 378's progress notes and vital signs, LVN 1 stated there were no corresponding documentation of the blood pressure (BP) measurements elsewhere, nor if the blood pressure were outside of parameter for the aforementioned doses. During an interview on 3/12/20 at 9:45 a.m., the DON stated there was a potential the aforementioned doses were not actually administered, or omitted. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to check temperatures of food items prior to serving the residents, to label refrigerated liquid items and to practice infection control procedures during the preparation of food items. These deficient practices placed the residents at increased risk for foodborne illnesses. Findings: a. During an observation of the facility trayline, on 3/13/2020 at 6:26 a.m., it was noted that Kitchen Staff (KS 1) plated two boiled eggs and two pancakes without having first performing a temperature check to ensure that food items met mandates of 142 degrees Fahrenheit (F, unit of temperature). During an observation of the facility trayline on 3/13/2020 at 6:55 a.m., it was noted that KS 1 neglected to perform a temperature check for the following items on the trayline: cream of wheat, oat meal, fried eggs and pancakes. During an interview on 3/13/2020 at 9:16 a.m, KS 1 stated the she did not check the cream of wheat, oatmeal, fried egg and pancake before plated said food items. KS 1 stated the food temperatures were not checked as required and all food items were to be checked and measured at the appropriate temperature before being plated for residents' consumption. A review a facility policy dated September 2017, titled Safe Food Handling indicated all hot food placed in heated wells of steam table must be maintained at a minimum of 135 degrees F when placed in the heated well. b. During the initial tour of the facility kitchen on 3/10/2020 and 10:49 a.m., there were 30 cups of white colored fluid observed that were not dated or labeled. During an interview on 3/10/20 at 10:51 a.m., the Dietary Supervisor (DS) stated the milk was not dated or labeled by kitchen staff, but labeling food items and liquid was a required practice within the facility kitchen. c. During a kitchen observation on 3/13/2020 at 6:32 a.m., KS 1 removed a cardboard box from a freezer, while touching the sides of the cardboard box with the gloved hand used to prepare food items for the trayline. KS 1 proceeded to place cardboard box on the food preparation area adjacent to the food steamer for the trayline. KS 1 was observed to open the cardboard box with gloved hands and without removing the contaminated glove or perform hygiene, KS 1 removed meat product with the gloved hand and place the meat product on the grill. KS 1 then removed the cardboard box containing meat products and placed it back in the freezer without removing contaminated gloves. During an interview on 3/13/2020 at 9:20 a.m., KS 1 stated she touched the cardboard box and failed to perform hand hygiene before touching the meat product and preparing it. KS 1 stated, I didn't think about that. KS 1 stated she now understood the importance of [MEDICATION NAME] hand hygiene when coming in contact with contaminated items to prevent residents from getting sick. A review of facility policy dated February 2009, titled Personnel Sanitation Standards indicated hands must be washed after each trip to the restroom, after leaving storage rooms, washrooms, etc., after touching the hair, mouth, or nose, and at any other time it is necessary. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure a nasal cannula (NC) tubing (a device consists of a lightweight tube which on one ends splits into two prongs which are placed in the nostrils and from which a mixture of air and oxygen flows) and oxygen humidifier (a medical device used to provide long-[MEDICATION NAME] moisture during oxygen therapy) was labeled with the replacement date and time for one of 18 sampled residents (Resident 19). This deficient practice had the potential for harboring bacteria and placed the resident at risk for infection. Findings: On 3/10/20 at 2:00 p.m., Resident 19 was observed receiving oxygen with humidification (a medical device used to provide long-[MEDICATION NAME] moisture during oxygen therapy) at 3 liters per minute (LPM, unit of volume) through a nasal cannula (NC). Both the oxygen humidifier and nasal cannula were observed with no date and time labeled. A review of Resident 19's Admission Record indicated the resident was admitted by the facility on 1/31/20 with [DIAGNOSES REDACTED].), and [MEDICAL CONDITION] (the loss of the ability to move all four limbs). A review of Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 7/24/19, indicated Resident 19 had severe cognitive (ability to make decisions of daily living) impairment with daily decision making and required total dependence on activities such as positioning, transfers, bathing, and eating. During an interview on 3/12/20 at 9:38 a.m., licensed vocational nurse 5 (LVN 5) stated both Resident 19's oxygen humidifier and nasal cannula were not labeled with date and time, and were supposed to be labeled with date and time when replaced. During an interview on 3/12/20 at 9:51 a.m., the Assistant Director of Nursing (ADON) indicated, nasal cannula tubings were replaced every Sunday morning during the 7-3 shift and as needed (PRN) for all residents receiving oxygen therapy and the nasal cannula should either be labeled with date and time written on a piece of tape and then placed on the tubing or labeling the date and time written directly on the tubing. The ADON stated the oxygen humidifiers should be labeled with date and time when replaced. The ADON stated Resident 19's nasal cannula tubing and oxygen humidifier needed to be labeled with both date and time for infection control measures and prevention from harboring bacteria. A review of the facility's policy dated 8/2014, titled Oxygen Administration, indicated to label nasal cannula tubings and humidifier with date and time opened. Change humidifier and tubing per facility procedure. Humidifier should be labeled with date and time changed. |
| F 0881<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Implement a program that monitors antibiotic use.**<br><br>Based on interview and record review the facility failed to follow their policy for Antibiotic Stewardship Program (ASP) by not using McGeer's criteria (according to National Institute of Health (NIH a governmental bio-medical research agency), is a standard of practice using categories of which two or more must be met to determine if a resident is a candidate for antibiotic use). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 36/ This deficient practice has the potential to place the residents at risk for the development of antibiotic-resistant organisms (a strain of infectious organisms that have developed a resistance to antibiotics) and side effects from antibiotic due to unnecessary or inappropriate antibiotic use. Findings: During a concurrent interview and record review on 3/12/20 at 9:09 a.m., the Infection Preventionist (IP) stated she was responsible for the facility's antibiotic stewardship program (ASP). The IP stated the facility did not use McGeer's criteria for screening residents before administering antibiotics. The IP stated the ASP was important for the facility residents because they could get superbugs from unnecessary antibiotic use, or get additional infections because the antibiotic killed their natural flora (naturally existing bacteria found in the body such as the intestines, the mouth and the skin. These natural bacteria help protect the body from infections). A review of the facility policy titled antibiotic Stewardship Program, dated 11/2017 indicated the rational for an ASP is because antibiotics are one of the most frequently prescribed medications in nursing homes, and an estimated 40 - 75 percent of antibiotic prescriptions in nursing homes may be inappropriate. The extensive use of antibiotics results in the risk of not only adverse drug reactions, but also the development of antibiotic-resistant or even multidrug resistant organisms, which pose a significant risk to the facilities population. |