STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA GLEN CARE CENTER	**638 E COLORADO AVENUE GLENDORA, CA 91740**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat the resident with respect and dignity by not covering the resident's urinary catheter (urinary catheter is a tube placed in the body to drain and collect urine from the bladder) bag, for one of two sampled residents (Resident 61). This deficient practice placed the resident at risk for humiliation and loss of dignity. Findings: A review of the facility's Face Sheet indicated Resident 61 was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 1/23/20 indicated Resident 61 had unclear speech, usually made self understood and able to understand others. Resident 61 required extensive assistance (resident involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person assist for personal hygiene and two persons physical assist for bed mobility. On 3/14/20 at 7:36 a.m., during an observation and concurrent interview, Resident 61 was lying in bed with urinary catheter bag hanging on the side rail of the resident's bed. Resident 61's urinary bag was not covered. Licensed Vocational Nurse 1 (LVN 1) verified the finding and stated urinary bag should be covered for dignity of the resident. On 3/14/20 5:27 p.m., during an interview, LVN 2 stated urinary catheter bag should be covered to promote dignity of Resident 61. A review the facility's policy and procedure titled Quality of Life-Dignity dated August 2009 indicated, demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy to promptly notify the resident's attending physician and representative of changes in the resident's condition and/or status for two of four sampled residents (Resident 288 and Resident 89). a. For Resident 288, the facility failed to notify the resident's representative pertaining to the change of condition on [DATE]. b. For Resident 89, the facility failed to notify the resident's attending physician of Resident 89's abnormal vital signs (measurements of the body's most basic functions). These failures had the potential to prevent resident's representative from making informed decisions about care for the resident and had the potential for the resident not to be evaluated and treated promptly and accordingly. Cross Reference to F684 Findings: a. A review of an admission record indicated Resident 288 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. blood to the rest of the body). A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated [DATE], indicated Resident 288's cognitive skills for daily decision making was moderately impaired. Resident 288 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, eating, and personal hygiene, and was totally dependent on staff for toilet use and bathing. A review of Resident 288's physician's orders [REDACTED]. During a concurrent interview and record review on [DATE], at 12:23 p.m., Registered Nurse 2 (RN 2) reviewed Resident 288's medical record and he was unable to find a documented evidence that Resident 288's representative was notified on the change of condition (COC) on [DATE]. RN 2 stated there was no COC form and/or nurse's notes pertaining to the COC. RN 2 stated family or resident's representative should be notified of any COC and it should be documented. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, dated [DATE], indicated, the facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental condition and/or status. b. A review of Resident 89's Face Sheet (admission record) indicated the facility admitted the resident on [DATE]. A review of Resident 89's Physician admission orders [REDACTED]. A review of Resident 89's Physician order [REDACTED]. The POLST indicated to relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of [REDACTED]. A review of Resident 89's Nurses Notes dated [DATE] and timed at 7:00 p.m., indicated the resident arrived under hospice care (medical service designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, tailored to the patient's needs and wishes). The notes indicated the resident's blood pressure (the pressure of circulating blood on the walls of blood vessels) was ,[DATE] (low) and used his abdominal muscles with respirations. During a review of Resident 89's medical record on [DATE] at 11:10 a.m., the facility's Director of Nursing (DON) stated the resident's Nurses Notes dated [DATE] and timed at 12:00 a.m. indicated the resident did not look good, and did not respond. The DON stated the notes indicated the resident's blood pressure was ,[DATE] (low), temperature 100.8 (elevated body temperature), and heart rate of 131 (fast), and oxygen saturation (a measure of how much oxygen the blood is carrying) was 88% (low). DON stated the nurses (not identified) did not notify the resident's physician. During the concurrent Resident 89's medical record review, DON stated the nurses were supposed to notify the physician so that the physician could decide which interventions were necessary for the resident and to make the resident comfortable. A review of Resident 89's Nurses Notes dated [DATE] and timed at 1:30 a.m., indicated the resident expired at 3:21 a.m. A review of the facility's policy and procedure titled Change in a Resident's Condition or Status, with a revised date [DATE], indicated the facility should promptly notify the resident, his her attending physician, and representative of changes in the resident's medical/mental condition and/or status.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a homelike environment for one of 21 sampled residents (Resident 55) by failing to follow its policy to do an inventory list of resident's personal belongings and clothing upon admission. This failure had the potential not to readily identify resident's lost belongings. Findings: A review of an Admission Record indicated Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/3/20, indicated Resident 55's cognition (a mental process of acquiring knowledge and understanding) was moderately impaired and had the ability to express ideas and wants and ability to understand others. Resident 55 required extensive

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and independent for eating. During an interview on 3/14/20, at 11:14 a.m., Resident 55 stated she had a missing blanket and shoes. Resident 55 stated the facility staff did not do an inventory list when she was readmitted to the facility and staff were not updating her inventory list if she brought additional items. During a concurrent interview and record review on 3/14/20, at 4:56 p.m., with Social Service Director (SSD), SSD reviewed Resident 55's medical record and he was unable to find an inventory list. SSD stated there should be an inventory list on readmission on 1/29/20 to account the resident's personal belongings and used as reference if they have missing items. SSD stated, resident's personal belongings and clothing should be inventoried and documented upon admission, readmission, yearly, and updated as needed. SSD stated, the facility had a form for theft and loss, investigate, and replace or reimburse the resident if unable to find belongings. A review of the facility's policy and procedure titled, Personal Property, dated September 2012, indicated, the resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on observation, interview, and record review, the facility failed to conduct a thorough pre-employment screening process for Certified Nursing Assistant 4 (CNA 4). The facility did not conduct a criminal background check for CNA 4. This deficient practice had the potential to expose the residents to abuse and neglect. Findings: During a review of CNA 4's employee file on 3/15/20 at 10:04 a.m., the facility's Director of Staff Development (DSD) stated the facility hired CNA 4 on 1/18/19 and conducted a criminal background check on 1/19/19 (a day after hiring). The DSD stated the criminal background check should be done prior to employment to ensure staff did not have a criminal record and to protect the residents from potential abuse. A review of the facility's undated policy and procedure titled Abuse Prevention/Prohibition, indicated the facility will not condone any form of resident abuse, neglect, misappropriation of property, exploitation and/or mistreatment. The policy indicated the facility screened potential employees for history of abuse, neglect, or mistreating residents.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Office of the State Long- Term Care Ombudsman upon transfer to General Acute Care Hospital (GACH) for one of two sampled residents (Resident 78). This deficient practice failed to provide protection to the resident from being inappropriately discharged . Findings: A review of the face sheet indicated Resident 78 was admitted to facility on 8/28/19 and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) for Resident 78, dated 12/4/19, indicated the resident's cognitive(process of acquiring knowledge and understanding) skills for daily decision making was severely impaired and required supervision from staff for her activities of daily living. A review of the physician's telephone order, dated 2/4/20, at 12:00 noon, indicated Transfer resident to GACH rule out altered mental status, failure to thrive,cough,congestion. A review of the Resident Transfer Record, indicated, Resident 78 was transferred to GACH on 2/4/20. A review of the recapitulated physician order for [REDACTED]. RN1 was not able to find documented evidence in the resident's clinical record that the Office of the State Long- Term Care Ombudsman was notified that Resident 78 was transferred to GACH on 2/4/20. A review of the facility policy and procedure, titled Notice Of Transfer/discharge date d October 2018, indicated, before the transfer or discharge occurs, the facility must notify the resident and, if known, the responsible party and Ombudsman of the transfer and reasons for the transfer and document in the resident's clinical record. A facility representative will retrieve the completed Notice of Proposed Transfer and Discharge form from the clinical record and mail/fax it to the resident, responsible party and Ombudsman, and document in the clinical record that the notice was mailed/fax to whom it was mailed/fax and the date of mailing/fax. A copy of the notice will be maintained in the medical record. The certified mail receipt will be attached to the chart copy of the notice.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's oxygen use for one of 21 sampled residents (Resident 30). This failure had the potential for the resident not to receive appropriate interventions and care services. Findings: A review of an Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/20/20, indicated Resident 30's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 30 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and independent for eating. A review of Resident 30's physician's (MD) order, dated 12/17/19, indicated may use oxygen (O2) at two liters per minute (LPM) via nasal cannula (NC- a device used to deliver supplemental O2 through the nose) to keep O2 saturation (an estimate of the amount of oxygen in the blood) more than 92 percent (%) continuously. The order clarified on 2/23/20, indicated may continuously use O2 at two LPM via NC to maintain O2 saturation above 92% for [MEDICAL CONDITION]. During an observation on 3/14/20, at 7:30 a.m., in the resident's room, Resident 30 had O2 at two LPM with humidifier via NC. During a concurrent interview and record review on 3/15/20, at 3:13 p.m., Director of Nursing (DON) reviewed Resident 30's MD order and Medication Administration Record [REDACTED]. DON stated Resident 30 needs oxygen to prevent shortness of breath. DON reviewed Resident 30's MDS dated [DATE] and stated the use of oxygen was not reflected in the MDS section O0100C (O2 therapy). DON stated, the MDS should be accurate to reflect the actual condition of the resident to have an accurate care planning. A review of the Centers for Medicare and Medicaid Services (CMS) Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual MDS 3.0, Version 1.17.1, dated October 2019, indicated, to review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days included O2 therapy. Check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility and within the 14-day look-back period included O2 therapy. MDS section O0100C, oxygen therapy, indicated to code continuous or intermittent O2 administered via mask, cannula, etc., delivered to a resident to relieve [MEDICAL CONDITION] (low amount of oxygen reaching the tissue of the body) in this item.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to include the physician's order for oxygen therapy and indicate interventions in the baseline care plan for one of 21 sampled residents (Resident 30). This deficient practice had the potential for the resident not to receive interventions to address specific care needs which placed the resident at risk for respiratory distress. Findings: A review of an Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/20/20, indicated Resident 30's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 30 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and independent for eating. A review of Resident 30's physician's (MD) order, dated 12/17/19, indicated may use oxygen (O2) at two liters per minute (LPM) via nasal cannula (NC- a device used to deliver supplemental O2 through the nose) to keep O2 saturation (an estimate of the amount of oxygen in the blood) more than 92 percent (%) continuously. The order clarified on 2/23/20 indicated may continuously use O2 at two LPM via NC to maintain O2 saturation above 92% for [MEDICAL CONDITION]. During an observation on 3/14/20, at 7:30 a.m., in the resident's room, Resident 30 had O2 at two LPM with humidifier via NC. During a concurrent interview and record review on 3/15/20, at 7:11 a.m., Director of Nursing (DON) reviewed Resident 30's Baseline Care Plan (BCP) dated 12/17/19 and stated the use of O2 therapy was not address on the BCP and there were no

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) interventions indicated in the BCP. The DON stated, BCP was developed within 24 hours and MD order such as O2 therapy should be included in the BCP. DON stated, the plan of care should prioritize what kind of care provided and there should be interventions to address the needs of the resident. A review of the facility's undated policy and procedure titled, Baseline Care Planning, indicated, it is the policy of this facility to develop and provide a BCP for each resident that includes the instruction needed to provide effective and person-centered care that meets professional standard and quality of care. The BCP will include the minimum healthcare information necessary to properly care for a resident included physician orders . The facility must implement the interventions to assist the resident to achieve care plan goals and objectives.
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 a comprehensive person-centered care plan for five of 21 sampled residents (Residents 45, 53, 81, 339, and 30) as indicated in the facility's policy and procedure. a. For Resident 45, there was no individualize care plan to address the use of [MEDICATION NAME] (drug to treat depression) 75 milligrams (mg), as ordered. b. For Resident 53, there was no individualize care plan to address the use of antibiotic (drug to kill bacteria) for urinary tract infection, as ordered. c. For Resident 81, there was no individualize care plan to address the weight loss on 3/1/20 and the use of grab bars (adjustable metal or rigid plastic bars that attach to the bed). d. For Resident 339, there was no individualize care plan to address the [DIAGNOSES REDACTED]. e. For Resident 30, the facility failed to develop a comprehensive care plan in a timely manner to address the use of oxygen. Resident 30 was re-admitted on [DATE] and the care plan for the use of oxygen was initiated on 2/19/20. These deficient practices had the potential for the residents not to receive interventions to address specific care needs. Findings: a. A review of the face sheet indicated Resident 45 was admitted to facility on 1/8/20, and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) for Resident 45, dated 1/15/20, indicated, the resident's cognitive skills (process of acquiring knowledge and understanding) for daily decision making was intact and required extensive to total assistance from staff for her activities of daily living. Section N of the MDS indicated Resident 45 received antidepressant medication for the last seven days. A review of Resident 45's recapitulated physician's orders [REDACTED]. Order was dated 2/21/20. On 3/15/20, at 9:14 a.m., during an interview and record review, Registered Nurse 1 (RN 1) stated Resident 45 was on [MEDICATION NAME] 75 mg 1 tab via [DEVICE] every 12 hours for depression. RN 1 stated the care plans for Resident 45 for altered behavior symptoms (depression), dated 2/14/20 and depression manifested by loss of interest, dated 2/15/20, both did not indicate interventions specific for the use of [MEDICATION NAME] medication. A review of the facility's policy and procedure, titled Care Plans-Comprehensive, revised September 2010, indicated, an individualized comprehensive care plan that include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Area of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessment) before interventions are added to the care plan. b. A review of the face sheet indicated Resident 53 was admitted to facility on 11/30/19, and was readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) for Resident 53, dated 1/27/20, indicated the resident's cognitive skills for daily decision making was intact and required supervision to extensive assistance from staff for the activities of daily living. Section N of the MDS indicated Resident 53 received antibiotic medication for the last seven days. A review of Resident 53's physician's telephone indicated [MEDICATION NAME] one gram (1 gm) intravenously (IV) daily for UTI for four days. Last dose to be given 1 /24/20. The order was dated 1/20/20, at 9:24 p.m., A review Resident 53's Nurse Notes dated 1/20/20, timed at 7:35 p.m., indicated Resident 53 was readmitted to the facility to continue with antibiotic therapy IV [MEDICATION NAME] 1 gm for 4 days. On 3/15/20, at 8:23 a.m., during an interview and record review, Registered Nurse 1 (RN 1) was not able to find the comprehensive care plan in the clinical record of Resident 53 for the use of antibiotics ([MEDICATION NAME] 1 gm IV) as ordered. RN 1 confirmed there was no care plan for Resident 53 for the use of antibiotics. A review of the facility's policy and procedure, titled Care Plans-Comprehensive, revised September 2010, indicated, an individualized comprehensive care plan that include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Area of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessment) before interventions are added to the care plan. c. A review of Resident 81's untitled admission record indicated the facility admitted the resident on 9/5/17 and readmitted her on 2/20/20 with [DIAGNOSES REDACTED]. A review of Resident 81's untitled document dated 2/2/120 indicated the resident did not have the capacity to understand and make decisions. A review of Resident 81's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated [DATE] indicated the resident had severe impairment for daily decision making and required supervision to eat. A review of Resident 81's Weekly Weight Form dated 2/23/20 indicated the resident weighed 93 pounds (lbs., unit of weight). A review of Resident 81's Weekly Weigh Form dated 3/1/20 indicated the resident weighed 90 lbs. (three lbs. weight loss). During a dining observation on 3/14/20 at 12:59 p.m., Resident 81 was sitting in a wheelchair eating in the dining room. During an observation on 3/14/20 at 7:11 a.m., Resident 81 was lying in bed and the bed had two-bed grab rails that were up. During a review of Resident 81's medical record on 3/14/20 at 7:41 a.m., the facility's Director of Nursing stated there was no care plans for the use of grab bars. During a review of Resident 81's medical record on 3/14/20 at 11:32 a.m., Registered Nurse 1 (RN 1) stated there was no care plan to address the residents' three pounds weight loss. RN 14 stated there were no interventions and no goals in place. A review of the facility's policy and procedure titled Care Plans-Comprehensive, with a revised date of September 2010 indicated that an individualized comprehensive care plan that included measureable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. The policy indicated that the resident's care plans were to incorporate identified problem areas. d. A review of Resident 339's Face Sheet indicated the facility admitted the resident on 3/4/20. A review of Resident 339's history and physical examination [REDACTED]. A review of Resident 339's MDS dated [DATE] indicated the resident had severe impairment for daily decision-making. During a review of Resident 339's medical record on 3/14/20 at 10:13 a.m., Registered Nurse 1 (RN 1) stated there was no care plans to address the residents' [DIAGNOSES REDACTED]. During an observation on 3/14/20 at 6:52 a.m., Resident 339 was lying in bed and had her eyes closed. During a review of Resident 339's medical record on 3/14/20 at 10:12 a.m., Registered Nurse 1 stated. A review of the facility's policy and procedure titled Care Plans-Comprehensive, with a revised date of September 2010 indicated that an individualized comprehensive care plan that included measureable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. The policy indicated that the resident's care plans were to incorporate identified problem areas. e. A review of an Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/20/20, indicated Resident 30's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 30 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and independent for eating. A review of Resident 30's physician's (MD) order, dated 12/17/19, indicated may use oxygen (O2) at two liters per minute (LPM) via nasal cannula (NC- a device used to deliver supplemental O2 through the nose) to keep O2 saturation (an estimate of the amount of oxygen in the blood) more than 92 percent (%) continuously and clarified on 2/23/20, indicated may continuously use O2 at two LPM via NC to maintain O2 saturation above 92% for [MEDICAL CONDITION]. A review of Resident 30's Care Plan Oxygen Use, dated 2/19/20, indicated use of continuous O2 to maintain O2 saturation above 92% due to episodes of difficulty breathing/shortness of breath secondary to [DIAGNOSES REDACTED]. During an observation on 3/14/20, at 7:30 a.m., in the resident's room, Resident 30 had O2 at two LPM with humidifier via NC and O2 tubing was not dated. During a concurrent interview and record review on 3/15/20, at 7:24 a.m., Director of Nursing (DON) reviewed Resident 30's comprehensive care plan (CCP) for oxygen use dated 2/19/20 and stated Resident 30 CCP should be done within three days

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) after readmission on 12/17/19 per facility process. DON stated it was not done in a timely manner. DON stated CCP should be develop in a timely manner to address and meet the resident's needs. A review of the facility's policy and procedure titled, Care Plans-Comprehensive, dated September 2010, indicated, an individualized comprehensive care plan that include measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs. The comprehensive care plan is based on a thorough assessment that includes, but not limited to the MDS.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **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 ensure that three of 21 sampled residents (Resident 89, Resident 288, and Resident 339) received treatment and care in accordance with professional standards of practice and nursing assessment specific to each resident. a. For Resident 89, the facility failed to implement nursing interventions when the resident had a change of condition. b. For Resident 339, the facility failed to assess the resident after the resident presented with a change of condition. c. For Resident 288, the facility failed to assess the resident and/or provide necessary interventions pertaining to the change of condition on [DATE]. These deficient practices had the potential for the residents not to receive appropriate treatment and had the potential for harm. Findings: a. A review of Resident 89's Face Sheet (admission record) indicated the facility admitted the resident on [DATE]. A review of Resident 89's Physician admission orders [REDACTED]. A review of Resident 89's Physician order [REDACTED]. The POLST indicated to relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of [REDACTED]. A review of Resident 89's Nurses Notes dated [DATE] and timed at 7:00 p.m., indicated the resident arrived under hospice care (medical service designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, tailored to the patient's needs and wishes). The notes indicated the resident's blood pressure (the pressure of circulating blood on the walls of blood vessels) was ,[DATE] (low) and used his abdominal muscles with respirations. During a review of Resident 89's medical record on [DATE] at 11:10 a.m., the facility's Director of Nursing (DON) stated the resident's Nurses Notes dated [DATE] and timed at 12:00 a.m. indicated the resident did not look good, and did not respond. The DON stated the notes indicated the resident's blood pressure was ,[DATE] (low), temperature 100.8 (elevated body temperature), and heart rate of 131 (fast), and oxygen saturation (a measure of how much oxygen the blood is carrying) was 88% (low). The DON stated the nurses (not identified) did not notify the resident's physician. A review of Resident 89's Nurses Notes dated [DATE] and timed at 1:30 a.m., indicated the resident expired at 3:21 a.m. During the concurrent review of Resident 89's medical record, DON stated the nurses were supposed to notify the physician so that the physician could decide which interventions were necessary for the resident. A review of the facility's policy and procedure titled Change in a Resident's Condition or Status, with a revised date [DATE], indicated the facility should promptly notify the resident, his her attending physician, and representative of changes in the resident's medical/mental condition and/or status. b. A review of Resident 339's Face Sheet indicated the facility admitted the resident on [DATE]. A review of Resident 339's history and physical examination [REDACTED]. A review of Resident 339's Minimum Data Set (MDS- a resident assessment and care screening tool) dated [DATE] indicated the resident had severe impairment for daily decision-making. A review of Resident 339's Short Term Problems dated [DATE], indicated to monitor the resident's temperature. A review of Resident 339's SBAR Communication Form dated [DATE] and timed at 12:00 p.m., indicated the resident had an elevated temperature of 100.2 (elevated). During an observation on [DATE] at 6:52 a.m., Resident 339 was lying in bed and had her eyes closed. During a review of Resident 339's medical record on [DATE] at 10:12 a.m., Registered Nurse 1 stated the resident's Nurse's Notes indicated that the nurses did not conduct complete nursing assessments on [DATE], [DATE] and [DATE]. RN 1 stated the nurses were supposed to monitor the resident for a total of 72 hours every shift after Resident 339 had a change of condition on [DATE]. A review of the facility's policy and procedure titled Change in a Resident's Condition or Status, revised [DATE] indicated the nurse supervisor/charge nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. c. A review of an admission record indicated Resident 288 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated [DATE], indicated Resident 288's cognitive skills for daily decision making was moderately impaired. Resident 288 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, eating, and personal hygiene, and was totally dependent on staff for toilet use and bathing. A review of Resident 288's physician's (MD) order, dated [DATE], indicated to transfer Resident 288 to General Acute Care Hospital (GACH) via 911 for respiratory distress. During a concurrent interview and record review on [DATE], at 12:23 p.m., with Registered Nurse (RN) 2, RN 2 reviewed Resident 288's medical records and he was unable to find a documentation for assessment and/or intervention implemented pertaining to the change of condition (COC) on [DATE]. RN 2 stated there was no COC form which included assessment and/or nurse's notes pertaining to the COC on [DATE]. RN 2 stated if resident had COC, the licensed nurse should do assessment, notify MD and family, follow the MD order, implement intervention to manage the COC, monitor the resident, and update the care plan, and it should be documented. RN 2 stated if unable to manage the COC then resident will be transferred to the hospital. RN 2 stated there should be an assessment and intervention implemented to manage the COC and meet the needs of the resident. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, dated [DATE], indicated, prior to notifying the physician, the nurse will make detailed observation and gather relevant and pertinent information . The nurse supervisor/charge nurse will record in the resident's medical record the information relative to changes in the resident's medical/mental condition or status.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary care and services to maintain skin integrity and prevent pressure ulcers (localized damage to the skin and underlying soft tissue over a bony area) for four of four sampled residents (Residents 61, Resident 63, Resident 44, and Resident 288) by failing to : a. Ensure that bilateral elbow paddings were applied to Resident 61 for skin maintenance prevention per physician's orders [REDACTED]. These failures placed the residents at risk for skin breakdown and/or developing pressure ulcers. Findings: a. A review of the facility's Face Sheet indicated Resident 61 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 1/23/20 indicated Resident 61 had unclear speech, usually made self understood and was able to understand others. Resident 61 required extensive assistance (resident involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person assist for personal hygiene and two persons physical assist for bed mobility. A review of Resident 61's physician's orders [REDACTED]. A review of Resident 61's care plan dated 11/6/19 indicated the resident was high risk for pressure ulcer secondary to immobility, diabetes mellitus (a chronic condition that affects the way your body metabolizes sugar) and right posterior thigh [MEDICAL CONDITION] with intervention of bilateral elbow paddings. On 3/14/20 at 7:36 a.m., during an observation, Resident 61 was lying in bed. Resident 61 was wearing a short sleeve shirt, no pads were applied on bilateral elbows. On 3/14/20 at 6:02 p.m., during an interview, Treatment Nurse 2 (TN 2) verified the finding and stated, certified nursing assistants were supposed to apply the elbow pads to Resident 61. TN 2 stated, the treatment nurse was still responsible to make sure that the pads were applied to Resident 61's bilateral elbows for skin friction and injury prevention. TN 2 stated Resident 61 was at high risk for skin breakdown due to immobility and [MEDICAL CONDITION]. b 1. A review of the facility's Face Sheet indicated Resident 63 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set ((MDS) dated [DATE] indicated Resident 63 had clear speech, able to understand others and able to make self understood. Resident 63 required extensive assistance (resident involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person assist for bed mobility, dressing and personal hygiene. On 3/14/20 at 6:43 a.m., during an observation and concurrent interview, Resident 63 was lying in bed sleeping. Resident 63 was sleeping on Low Air Loss mattress. The LAL mattress controller dial was set at firm. There was a sticker on the controller indicating Setting at 180-210 lb (pound). Registered Nurse 3 (RN 3) verified Resident 63' LAL mattress setting and stated LAL mattress should be set based on the resident's weight not on firm with alternating pressure to prevent skin breakdown. Treatment Nurse 1 (TN 1) stated he was responsible for the setting of

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Resident 63's LAL mattress.TN 1 stated, the setting should be based on the resident's weight for prevention of skin breakdown. A review of Resident 63's weight log indicated the resident weighed 190 lb on 3/1/20. A review of Resident 63's care plan dated 2/9/20 indicated the resident was at risk for skin breakdown related to hypertension (increased blood pressure), poor ADL (activity daily living) functioning and incontinent bowel and bladder. Intervention included LAL mattress for skin maintenance prevention setting at 180-210 lb. A review of the LAL mattress operator's manual provided by the facility, indicated, determine the patient's weight and set the control knob to that weight setting on the control unit. A review of the facility's policy and procedure titled Support Surface Guidelines dated September 2013 indicated, review the resident's care plan to assess for any special needs of the resident; assemble the equipment and supplies as needed; any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, air-loss or gel when lying in bed. b 2. A review of an Admission Record indicated Resident 44 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 1/7/20, indicated Resident 44's cognitive skills for daily decision making was moderately impaired. Resident 44 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, and personal hygiene and was totally dependent on staff with one person physical assist for toilet use and bathing. Resident 44 was at risk of developing pressure ulcer (a localized damage to the skin and underlying soft tissue over a bony area). A review of Resident 44's physician's orders [REDACTED]. Monitor LAL mattress function every shift. A review of Resident 44's Weight Record, dated 2/1/20, indicated Resident 44 weighed 95 pounds (lbs) and refused to be weighed in March 2020. During a concurrent observation and interview on 3/14/20, at 7:15 a.m., with Treatment Nurse (TN) 1, Resident 44's LAL mattress weight dial knob (pressure-adjust knob) setting was on firm (above 350 lbs). TN 1 changed the LAL settings between the range of 80-110 lbs as indicated in the label and stated it should be set in between the range of 80-110 lbs. b 3. A review of an admission record indicated Resident 288 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. blood to the rest of the body). A review of the MDS, dated [DATE], indicated Resident 288's cognitive skills (process of acquiring knowledge and understanding) for daily decision making was moderately impaired. Resident 288 required extensive assistance with one person physical assist for bed mobility, transfer, dressing, eating, and personal hygiene, and was totally dependent on staff for toilet use and bathing. Resident 288 was at risk of developing pressure ulcer. A review of Resident 288's physician's orders [REDACTED]. Monitor LAL mattress function every shift. A review of Resident 288's Nutritional Assessment, dated 3/13/20, indicated Resident 288's weight was 146 lbs. During a concurrent observation and interview on 3/14/20, at 7:17 a.m., with Treatment Nurse (TN) 1, Resident 288's LAL mattress weight dial knob (pressure-adjust knob) setting was on firm (above 350 lbs). TN 1 changed the LAL settings between the range of 120-150 lbs as indicated in the label and stated it should be set in between the range of 120-150 lbs. During an interview on 3/14/20, at 7:19 a.m., TN 1 stated, LAL mattress should be set according to the weight of the resident to prevent pressure ulcer or for skin maintenance. TN 1 stated, the facility should follow the manufacturer's guidelines in setting the LAL mattress to be effective. TN 1 stated the certified nurse assistant (CNA) should only push the static button and should not change the weight dial knob if the resident was repositioned. A review of the LAL mattress operator's manual provided by the facility, indicated, the product comes with an air cell mattress that provides low air loss, alternation and static pressure redistribution therapy. The operating instructions indicated on step six to determine the resident's weight and set the control knob to that weight setting on the control unit. In static mode, the mattress provides a firm surface that makes it easier for the resident to transfer or reposition.
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 follow its policy to secure the indwelling catheter (thin, sterile tube inserted into the bladder to drain urine into a bag outside the body) with a leg strap for one of one sampled resident (Resident 45). This failure had the potential for the resident to sustain injury if the indwelling catheter is accidentally pulled out. Findings: A review of an Admission Record indicated Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 1/15/20, indicated Resident 45's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 45 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, dressing, eating, and personal hygiene. Resident 45 was totally dependent on staff with one person physical assist for toilet use and bathing. A review of the physician's orders [REDACTED]. A review of Resident 45's Admission Nursing Assessment, dated 2/14/20, indicated Resident 45 had suprapubic urinary catheter. During a concurrent observation and interview on 3/14/20, at 7:04 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 45 had suprapubic urinary catheter connected to a urinary bag hung at the side of the bed and it was not secured with a leg strap. LVN 4 stated the tubing should be secured with a leg strap to the inner thigh of the resident to prevent injury and prevent the catheter from being pulled out. A review of the facility's policy and procedure titled, Catheter Care, Urinary, dated September 2014, indicated, ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. Note: Catheter tubing should be strapped to the resident's inner thigh.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for two of two sampled residents (Resident 30 and Resident 288). a. For Resident 30, the facility failed to date the oxygen tubing. b. For Resident 288, the facility failed to follow the physician's orders [REDACTED]. There was no oxygen saturation monitoring every shift and the oxygen humidifier and tubing were not dated. These deficient practices had the potential for adverse (harmful) consequences to the resident. Failure to label the tubing and oxygen humidifier also placed the resident at risk for infection. Findings: a. A review of an Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/20/20, indicated Resident 30's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 30 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. Resident 30 was independent for eating. A review of Resident 30's physician's (MD) order, dated 2/23/20, indicated may continuously use oxygen (O2) at two LPM via nasal cannula (NC- a device used to deliver supplemental O2 through the nose) to maintain O2 saturation above 92% for [MEDICAL CONDITION]. During a concurrent observation and interview on 3/14/20, at 7:30 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 30 had oxygen at two LPM with humidifier via NC and the oxygen tubing was not dated. LVN 4 stated, oxygen tubing was changed every Sunday and it should be dated in order to know when it was changed and for infection control. b. A review of an admission record indicated Resident 288 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. pump blood to the rest of the body). A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 1/20/20, indicated Resident 288's cognitive skills for daily decision making was moderately impaired. Resident 288 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, eating, and personal hygiene. Resident 288 was totally dependent on staff for toilet use and bathing. A review of Resident 288's physician's orders [REDACTED]. During an observation, interview, and record review on 3/14/20, at 7:28 a.m., with LVN 4, Resident 288 had oxygen with humidifier at three LPM via NC. The oxygen humidifier and oxygen tubing were not dated. LVN 4 stated oxygen humidifier and tubing should be dated in order to know when it was changed and for infection control. LVN 4 reviewed Resident 288's medical record and stated the oxygen order for Resident 288 was two LPM and not three LPM; there was no order to titrate and/or to monitor O2 saturation. There was no monitoring of oxygen saturation every shift in the Medication Administration Record [REDACTED]. LVN 4 stated, there should be monitoring of O2 saturation every shift if the resident was on O2 therapy to know if the resident was able to maintain the O2 saturation above 92% as ordered by the MD. LVN 4 stated, staff should call the MD to get an order for [REDACTED]. A review of the

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) facility's P&P titled, Departmental (Respiratory Therapy)-Prevention of infection, dated November 2011, indicated use distilled water for humidification per facility protocol. Mark bottle with date and initials upon opening and discard after 24 hours. Change the oxygen cannula and tubing every seven days or as needed.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services for two of two sampled residents (Resident 12 and Resident 22) receiving [MEDICAL TREATMENT] (HD- a procedure to remove fluids and toxins from the blood). a. For Resident 12, the facility failed to follow the physician's orders [REDACTED]. b. For Resident 22 who was on fluid restriction, the facility failed to monitor and document fluid intake every shift from 3/1/20 to 3/14/20. These failures had the potential for the resident to develop complications such as fluid overload and excessive bleeding and/or infection to the HD access site. Findings: a. A review of an Admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/21/20, indicated Resident 12's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 12 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. Resident 12 was independent for eating. Resident 12 was receiving [MEDICAL TREATMENT]. A review of Resident 12's physician's (MD) order, dated 8/31/19, indicated Resident 12 had HD every Tuesday, Thursday, and Saturday, with right chest tunneled catheter (HD access site), on fluid restriction of 2,000 milliliters (ml) per 24 hours, and limited to no water pitcher at the bedside. During a concurrent observation and interview on 3/14/20, at 9:52 a.m., Resident 12 had HD access site on the right chest. Resident 12 stated he had HD three times a week and sometimes the nurse check his HD access site before [MEDICAL TREATMENT] but did not check his access site after [MEDICAL TREATMENT]. Resident 12 stated he had HD scheduled today and the transportation was waiting for him. During a concurrent observation, interview, and record review on 3/14/20, at 10:03 a.m., with Registered Nurse (RN) 2, Resident 12 had several cans and bottles of juice, soda, and water at the bedside. RN 2 stated Resident 12 was on fluid restriction as ordered by the MD and there should be no beverages allowed at the bedside to prevent fluid overload. RN 2 stated MD order should be followed, notify the MD if resident was non-compliant, and do care planning. RN 2 reviewed Resident 12's medical records and he was unable to find any documentation regarding non-compliance on fluid restriction and/or if Resident 12 was educated on risk and benefits and/or if MD was notified. During a concurrent interview and record review on 3/14/20, at 12:43 p.m., Director of Nursing (DON) reviewed Resident 12's Nurse's [MEDICAL TREATMENT] Communication Record dated 1/23/20, 1/25/20, [DATE], 2/11/20, and 2/20/20. DON stated the post [MEDICAL TREATMENT] assessment were blank on the mentioned dates which indicated that the resident was not assessed when he returned from [MEDICAL TREATMENT]. DON stated, [MEDICAL TREATMENT] assessment pre (before) and post (after) should be done and documented to ensure the HD catheter was intact and access site had no bleeding. DON stated, pre and post [MEDICAL TREATMENT] assessment should be completed including vitals signs, medication given, mental status, access site, dressing, and skin assessment. During a concurrent interview and record review on 3/15/20, at 10:39 a.m., DON reviewed Resident 12's physician's orders [REDACTED]. DON stated there should be no fluids at the bedside that may cause fluid overload. DON stated, the intake and output (I&O) should be monitored every shift and totaled daily to ensure the MD order was followed. DON reviewed Resident 12's I&O Record for March 2020 and confirmed there was no intake recorded on 3/1/20, 3/8/20, 3/10/20, and 3/11/20 for 3:00 p.m. to 11:00 p.m. shift, and there was no total intake and output recorded on 3/1/20 to 3/14/20. DON stated a blank documentation means it was not done. DON stated she did not know that Resident 12 was non-compliant on fluid restriction. A review of the facility's policy and procedure (P&P) titled, Encouraging and Restricting Fluids, dated October 2010, indicated, be accurate when recording fluid intake. Record fluid intake on the intake side of the I&O record. When resident has been placed on restricted fluids, remove the water pitcher and cup from the room. Document the amount of fluids consumed by the resident during the shift. A review of the facility's P&P titled, [MEDICAL TREATMENT] Access Care, dated September 2010, indicated, nurse should document in the resident's medical record every shift as follows: location of catheter, condition of dressing, if [MEDICAL TREATMENT] was done during the shift, and observations post [MEDICAL TREATMENT]. b. A review of the facility's Face Sheet indicated Resident 22 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. affects the pumping power of the heart muscles). A review of the facility's Minimum Data Set ((MDS) dated [DATE] indicated Resident 22 had unclear speech, usually able to make self understood and able to understand others. Resident 22 required limited assistance (resident involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person physical assist for bed mobility, dressing and personal hygiene. A review of Resident 22's physician's orders [REDACTED].=500 ml, 3-11=500 ml, 11-7=500 ml. A review of Resident 22's care plan titled [MEDICAL TREATMENT], dated [DATE] indicated the resident is on fluid restriction 1500 ml every 24 hours. The care plan interventions included to monitor I&O (Intake and Output) On 3/15/20 at 7:27 a.m., during an interview and a concurrent medical record review of Resident 22, Registered Nurse 2 (RN 2) stated he cannot find Resident 22's fluid intake and output record from 3/1/20 to 3/14/20. RN 2 stated, Resident 22 was on fluid restriction, so fluid intake and output should be monitored and documented on Resident 22's Intake and Output Record. RN 2 stated, if fluid restriction is not monitored, it may put Resident 22 at risk of fluid overload and cause medical problems. On 3/15/20 at 10:03 a.m., during an interview, Director of Nursing (DON) admitted and confirmed that the facility's licensed nurses did not monitor and document Resident 22's intake and output from 3/8/20 to 3/14/20. DON also stated, she cannot find Resident 22's intake and output record from 3/1/20 to 3/7/20. On 3/15/20 at 10:03 a.m., during an interview, Licensed Vocational Nurse 6 (LVN 6) stated she forgot to monitor and document Resident 22's intake and output last week (3/8/20 to 3/14/20). A review of the facility's policy and procedure titled Intake/Output dated March, 2020 indicated, intake and output may be recorded when the following conditions exist as a nursing measure or as prescribed by the physician: Fluid restriction-may be recorded for the duration of the order.
F 0700 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to observe safe practices for the use of bed rails (adjustable metal or rigid plastic bars that attach to the bed) for one of 21 sampled residents (Resident 81), as indicated in the facility's policy and procedure by failing to: 1. Obtain a physician's order prior to the installation of the bed grab rails. 2. Attempt to use other alternatives prior to the installation of the bed grab rails. 3. Obtain an informed consent from Resident 81's representative and review the risks and benefits prior to the installation of the bed grab rails. These deficient practices had the potential for harm and injury to the resident. Findings: A review of Resident 81's facesheet indicated the facility admitted the resident on 9/5/17 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 81's history and physical (H&P) dated 2/2/120 indicated the resident did not have the capacity to understand and make decisions. A review of Resident 81's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated [DATE] indicated the resident had severe impairment for daily decision making and required supervision to eat. During an observation on 3/14/20 at 7:11 a.m., Resident 81 was lying in bed and the bed had two-bed grab rails that were up. During a review of Resident 81's medical record on 3/14/20 at 7:41 a.m., the facility's Director of Nursing stated there was no physician orders, no care plan, no evaluation, and no informed consent for the use of grab bars for Resident 81. A review of the facility's policy and procedure titled Proper Use of Side Rails, revised October 2010, indicated the safe use of side rails as resident mobility aids and that an assessment would be made to determine the resident's symptoms or reason four using side rails. The policy indicated that less restrictive interventions would be incorporated in care planning, and to obtain a consent for side rail use.

F 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates**

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F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) **progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide timely physician services for one of 21 sampled residents (Resident 68) as indicated in the facility's policy and procedure. This deficient practice had the potential to affect Resident 68's medical care and services. Findings: A review of Resident 68's Face Sheet (admission record) indicated the facility admitted the resident on 1/28/20 and readmitted her on 2/19/20 with [DIAGNOSES REDACTED]. A review of Resident 68's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 2/23/20 indicated the resident had severe impairment for daily decision making and required extensive assistance for personal hygiene. A review of Resident 68's History and Physical dated 3/15/20 indicated the resident did not have the capacity to understand and make decisions. During an interview on 3/15/20 at 10:34 a.m., Registered Nurse 4 (RN 4) stated Resident 68's physician did not see the resident from her readmission on 2/19/20 until 3/15/20. RN 4 stated the physician had up to 72 hours to visit the residents after admission and readmission to the facility. A review of Resident 68's clinical record did not indicate that the physician visited and evaluated the resident, prior to 3/15/20 (24 days from the resident's re admission on 2/19/20). During an observation on 3/15/20 at 10:52 a.m., Resident 68 was inside the activities room sitting in a wheelchair calm and awake. A review of the facility's policy and procedure titled Physician Services, with a revised date of April 2013, indicated the medical care of each resident was under the supervision of a licensed physician. The policy indicated the physician would perform pertinent timely medical assessments.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility failed to complete an employee performance review (EPR) in a timely manner for at least once every 12 months and failed to document needed information in the form for two of four sampled certified nursing assistants (CNA 5 and CNA 6). CNA 5's date of hire was on 9/1/19, EPR was conducted on 1/3/20 (four months delayed), and the EPR form was incomplete. CNA 6's date of hire was on 1/8/20 and EPR was conducted on 3/11/20 (two months delayed). This failure had the potential for the resident not to receive appropriate care and services that could affect the residents' quality of life. Findings: A review of the facility's list of all currently employed CNAs with their hire date, indicated CNA 5's hire date was on 9/1/18 and CNA 6's hire date was on 1/8/20. During a concurrent interview and record review on 3/15/20, at 4:57 p.m., Director of Staff Development (DSD) reviewed CNA 5's Employee Performance Review (EPR) form dated 1/3/20. There was no name, job title, date of hire, date of last review, reason for review, total points, number of areas reviewed, and overall rating, in the form. CNA 5 signed the EPR form on 1/3/20. In another review, DSD reviewed CNA 6's EPR form dated 3/11/20 and it indicated date of hire on 1/8/20, date of last review- not applicable, and reason for review indicated annual. DSD stated the performance review for CNA 5 and CNA 6 were completed late and it should be done on their hire/employment anniversary date. DSD stated EPR should be done in a timely manner to determine the staff's weaknesses and provide training as needed to ensure that the staff were competent to take care of the residents. DSD stated the data on EPR form should be completed. A review of the facility's policy and procedure titled, In-Service Training Program, Nurse Aide, dated September 2011, indicated, the facility will complete a performance review of nurse aides at least every 12 months. In-service training will be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review, the facility failed to ensure Medication Administration Record [REDACTED]. This deficient practice had the potential for the resident not to receive necessary care/treatment. Findings: A review of the facility's Face Sheet indicated Resident 66 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set (MDS) dated indicated Resident 66 had clear speech, able to understood others and able to made self understood. Resident 66 required extensive assistance (resident involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person assist for bed mobility and dressing. A review of Resident 66's MAR indicated [REDACTED]. The same MAR indicated [REDACTED]. On 3/14/20 at 2:10 PM, during an interview, Director of Nursing (DON) stated licensed nurse who administered medications should sign their name, title and initial on MAR indicated [REDACTED]. The DON stated this is the policy of the facility to ensure medication was given to resident as scheduled. DON stated licensed nurses should provide full signature and title in MAR indicated [REDACTED]. On 3/14/20 at 2:46 PM, during an interview, Licensed Vocational Nurse 5 (LVN 5) stated she was the nurse assigned to Resident 66 on 3/7/20 AM-PM shift. LVN 5 admitted she forgot to initial for the medications administered to Resident 66 on that day. LVN 5 stated she should sign her initial right after administration of medications and she should have full signature and title documented on the designated space on MAR for the purpose of identifying who administered the medication to that particular resident. A review of the facility's policy and procedure titled Administering Medication dated December 2012 indicated .the individual administering the medication must initial the resident's MAR indicated [REDACTED].
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 observation, interview, and record review, the facility failed to ensure a clinician evaluated, identified, addressed, and verified the continuing need for the use of antipsychotic medication (to treat mental conditions) for one of 21 sampled residents (Resident 68). Resident 68's physician did not assess the resident upon readmission to the facility and did not evaluate, identify, address, verify, and document the continuing need for [MEDICATION NAME] (antipsychotic medication) 0.25 milligrams (mg, a unit of measurement). This deficient practice had the potential for inadequate monitoring for effectiveness and adverse consequences. Findings: A review of Resident 68's Face Sheet (admission record) indicated the facility admitted the resident on 1/28/20 and readmitted her on 2/19/20 with [DIAGNOSES REDACTED]. A review of Resident 68's Physician order [REDACTED]. A review of Resident 68's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 2/23/20 indicated the resident had severe impairment for daily decision making and required extensive assistance for personal hygiene. A review of Resident 68's History and Physical dated 3/15/20 indicated the resident did not have the capacity to understand and make decisions. During an interview on 3/15/20 at 10:34 a.m., Registered Nurse 4 (RN 4) stated Resident 68's physician did not see the resident from her readmission on 2/19/20, until 3/15/20, and did not evaluate, identify, address, and verify the continuing need for the use of [MEDICATION NAME]. During an observation on 3/15/20, at 10:52 a.m., Resident 68 was inside the activities room sitting in a wheelchair calm and awake. A review of the facility's policy and procedure titled Antipsychotic Medication Use, with a revised date of March 2015 indicated antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy indicated to re-evaluate the use of the antipsychotic medication at the time of admission and or within two weeks to consider whether the medication could be reduced, tapered, or discontinued.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.**

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper storage of medication and medication cart was free from expired medical supplies for one out of two medication carts inspected. This deficient practice had the potential for the residents use ineffective medication and expired medical supplies, put the resident at risk of declining medical condition. Findings: On 3/14/20 at 10:19 p.m., during an inspection of medication cart 2 of the facility and a concurrent interview, found an unopened [MEDICATION NAME] Flex injection ([MED] pen, a man-made [MED] that is used to control high blood sugar in adults and children with diabetes mellitus- a chronic condition that affects the way your body metabolizes sugar) and an opened [MEDICATION NAME] ([MED] with rapid onset and a shorter duration of activity) indicating opened on 2/13/20 and expired on 3/12/20. Licensed Vocational Nurse 1 (LVN 1) stated unopened [MED] should be kept inside refrigerator until open, and opened [MED] pen should be dated on the open day and removed from the cart after the expiration date. On 3/14/20 at 2:17 p.m., during an interview, Director of Nursing (DON) stated unopened [MED] should be kept in refrigerator until open. DON stated expired [MED] pen should be removed from the cart so it won't be given to the resident. DON stated expired medications were not effective any more and using expired medication was a potential harm to the resident. A review of the facility's policy and procedure titled Storage of Medications indicated .Medications shall not be kept on hand after the expiration date on the label except those awaiting destruction; [MED]-Store in the refrigerator, until it is opened. It may then be kept in the medication cart or the refrigerator. [MED] be discarded 28-30 days (per manufacture guidelines) after it has been opened .
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 verify all food items listed on the meal card for one of 21 sampled residents (Resident 338), as indicated in the resident's meal card ticket. During an observation on 3/14/20 at 7:25 a.m., Resident 338 did not receive one slice of wheat bread as indicated on her meal card. This deficient practice had the potential for Resident 338 not to receive an appropriate balanced meal. Findings: A review of Resident 338's Face Sheet (admission record) indicated the facility admitted the resident on 8/25/19 and readmitted her on 2/7/20 with [DIAGNOSES REDACTED]. A review of Resident 338's Diabetes Plan dated 2/20/20 indicated the resident was at risk for [MEDICAL CONDITION] (abnormal high blood sugar level) and [DIAGNOSES REDACTED] (abnormal low blood sugar level) and the plan was to provide the resident with the diet as ordered. A review of Resident 338's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 2/26/20 indicated the resident was cognitively intact for daily decision making and required supervision while eating. A review of Resident 338's history and physical examination [REDACTED]. A review of Resident 338's untitled and undated meal ticket indicated for the resident to receive fresh fruit, two fried eggs over medium, raisin brand, and one slice of wheat bread. During an observation on 3/14/20 at 7:25 a.m., Resident 338 was awake lying in bed and stated that in general she would miss food items from her tray. During the concurrent observation, Registered Nurse 2 (RN 2) stated Resident 338's tray did not have one slice of wheat bread as indicated on the resident's card meal ticket. RN 2 stated the resident received half of a slice and was supposed to receive one full slice of bread. A review of the facility's policy and procedure titled Menu Planning and Requirements, dated with a year of 2016, indicated menus were planned to provide nourishing, palatable, attractive meals that meet the nutritional needs of residents served.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy to identify resident's food allergy and preferences for two of 21 sampled residents (Resident 30 and Resident 288). These failure had the potential for the resident not being provided with an appropriate food alternatives and substitutes that could affect the nutritional status of these residents. Findings: a. A review of an Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/20/20, indicated Resident 30's cognition (a mental process of acquiring knowledge and understanding) was intact. Resident 30 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and independent for eating. A review of Resident 30's Baseline Care Plan dated 12/17/19, there was no food allergies and food preferences documented in the form. A review of Resident 30's Nutritional Evaluation History and Data Collection dated 12/23/19, there was no food allergies, food dislikes/intolerances, and food preferences documented in the form. During an interview on 3/14/20, at 9:57 a.m., Resident 30 stated facility served him food that he did not like such as pasta. b. A review of an admission record indicated Resident 288 was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 288's cognitive skills for daily decision making was moderately impaired. Resident 288 required extensive assistance with one person physical assist for bed mobility, transfer, dressing, eating, and personal hygiene, and was totally dependent on staff for toilet use and bathing. A review of Resident 288's Baseline Care Plan dated 3/10/20, there was no food allergies and food preferences documented in the form. A review of Resident 288's Nutritional assessment dated [DATE], there was no food allergies/intolerances and food preferences documented in the form. During a concurrent interview and record review on 3/15/20, at 10:49 a.m., with Dietary Supervisor (DS), DS reviewed Resident 30 and Resident 288's medical records and stated she was unable to find a documentation of the food allergies and food preferences for the two residents. DS stated food allergy and food preferences should be obtained on admission, readmission, quarterly, and update as needed to know the allergy, likes, and dislikes and meet the nutritional needs of the residents. DSD stated if food allergies and food preferences were not obtained, the residents had the potential to get food that they were allergic and/or residents might not eat because they do not want the food, and loss weight. A review of the facility's policy and procedure (P&P) titled, Food Allergies and Intolerances, dated October 2008, indicated, residents with food allergies and/or intolerances will be identified upon admission . All resident reported food allergies and intolerances will be documented in the assessment notes . A review of the facility's P&P titled, Resident Food Preferences, dated November 2015, indicated, individual food preferences will be assessed upon admission and communicated to the interdisciplinary team (IDT- members from different discipline who assess, coordinate, and manage each resident's comprehensive health care).
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.** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with the professional standards for food service and safety. This deficient practice had potential to result in food borne illnesses as a result of the residents' compromised health status. Findings: a. On 3/14/20, at 6:23 a.m., during an initial tour to the facility kitchen, it was observed there were 50 counts of overly ripe bananas and with dark spots on the peel, placed on the shelve. It was also observed some peeled bananas were black in the middle portion of bananas. During a concurrent interview with the dietary cook (DC) stated, We used over ripe bananas to make banana cake today. According to https://cooking stackexchange.com: Once the banana is black, the banana is garbage. The facility policy and procedure, titled Preventing Foodborne Illness-Food Handling Revised July 2014, indicated Unsafe food sources. b1. On 3/14/20, at 11:34 a.m., during a kitchen follow up observation, observed 27 over ripe and black bananas on the shelve. A concurrent interview Dietary Supervisor (DS) she stated we used the black bananas to make banana cake today. b2. On 3/14/20, at 1:00 p.m., during a kitchen follow up observation, it was observed the dietary aid/dish washer (DA/DW), prepared cranberry juice without wearing gloves. On 3/14/20, at 1:05 p.m., during an inspection and interview, dietary supervisor was observed DA/DW to have prepared and wrapped the cranberry juice's cups without gloves. During a concurrent

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) interview stated he needed to wear gloves to prepare cranberry juice. b3. On 3/14/20, at 1:30 p.m., during a tray distribution, it was observed treatment nurse 1 (TN 1) checked the tray cart without verifying the dietary list. On 3/14/20, at 2:40 p.m., during an interview TN 2 stated, I compare the food itself with the paper on the tray, checked the consistency of the food. On 3/14/20, at 2:52 p.m., during an interview director of nursing (DON) stated the nurse checked the special need with high risk special ordered list against tray cart, the licensed staff did not checked the physician's diet order list during meal distribution. The facility policy and procedure, titled Tray Identification no date, indicated Appropriate identification/coding shall be used to identify various diets. The Food Services Manager or Supervisor will check trays for correct diets before the food carts are transported to their designated areas. Nursing staff shall check each food tray for the correct diet before serving the resident. The facility policy and procedure, titled Purpose and Function of the Department dated 2016, indicated All activities of the Dining Services Department shall occur to meet the specified purposes and functions of the Dining Services Department as follows. To comply with physician diet orders for all residents, including those on therapeutic diets and those with special regulations. The facility policy and procedure, titled Food Preparation and Services Revised July 2014, indicated bare hand contact with food is prohibited. Gloves must be worn when handling food directly. However, gloves can also becomes contaminated and/or soiled and must be changed between tasks. Disposable gloves are single use items and shall be discarded after each use.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review, the facility failed to maintain the medical records of two of 21 sampled residents (Resident 339 and Resident 55) in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. This deficient practice had the potential to result in the residents' pertinent information will be missing the accurate assessments of these residents. Findings: a. A review of Resident 339's Face Sheet indicated the facility admitted the resident on 3/4/20. A review of Resident 339's history and physical examination [REDACTED]. A review of Resident 339's Short Term Problems dated 3/5/20, indicated to monitor the resident's temperature. A review of Resident 339's SBAR Communication Form dated 3/5/20 and timed at 12 p.m., indicated the resident had an elevated temperature of 100.2 (elevated). A review of Resident 339's Physician Telephone Orders dated 3/6/20 and timed at 9:30 a.m., indicated for the resident to receive laboratory services to check the resident's complete blood count (CBC, blood test that measures many different parts and features of your blood), comprehensive metabolic panel (CMP, a series of blood tests), and urinalysis (UA, a urine test) and urine culture and sensitivity (CS, identify the bacteria and to choose the best medication to treat the type of bacteria). A review of Resident 339's MDS dated [DATE] indicated the resident had severe impairment for daily decision-making. During an observation on 3/14/20 at 6:52 a.m., Resident 339 was lying in bed and had her eyes closed. During a review of Resident 339's medical record on 3/14/20 at 11:16 a.m., the facility's Director of Nursing (DON) stated there were no laboratory done. DON stated the resident's clinician canceled the laboratory orders and that she (DON) forgot to document. A review of the facility's policy and procedure titled Charting and Documentation, with a revised date of April 2008 indicated all services provided to the resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record. b. A review of an Admission Record indicated Resident 55 was originally admitted to the facility on [DATE] and the current readmission was on 1/29/20 with [DIAGNOSES REDACTED]. A review of Resident 55's Detail Admission/Discharge Report, dated 3/15/20, indicated Resident 55 had history of several readmissions from General Acute Care Hospital (GACH) on 4/15/19, 9/10/19, 9/21/19, and 1/8/20. A review of the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 2/3/20, indicated Resident 55's cognition (a mental process of acquiring knowledge and understanding) was moderately impaired and had the ability to express ideas and wants and ability to understand others. Resident 55 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and independent for eating. During an interview on 3/14/20, at 11:06 a.m., Resident 55 stated she lost 50 pounds (lbs) in two months. A review of the facility's weight variance logbook dated January 2020, indicated Resident 55 had weight loss on 1/19/20. The re-admission chart for 1/8/20 was requested from the DON, however, during an interview and record review on 3/15/20, at 9:17 a.m., Director of Nursing (DON) was unable to provide the clinical record. During an interview on 3/15/20, at 1:30 p.m. and 5:30 p.m., with DON, DON stated the medical record department was still looking for Resident 55's chart for the readmission on 1/8/20. During an interview on 3/15/20, at 6 p.m., with Medical Record Staff (MRS), MRS stated she was unable to find the whole chart of Resident 55 for the readmission on 1/8/20. MRS stated resident's medical record should be complete, accurate, readily accessible, and systematically organized per regulations. MRS stated facility should follow regulations. A review of the document provided by the facility titled, Record Systems Management, dated 10/2/18, indicated, the facility will always have a system available for identifying information within the Health Information/Medical Record Department that is consistent with the standards of professional practice.
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 follow its infection control policy and procedure on Handwashing/Hand Hygiene. Certified Nursing Assistant 2 (CNA 2) failed to perform hand hygiene after direct contact with resident care and soiled linen. This deficient practice had the potential to spread germs. Findings: During an observation on 3/14/20 at 9:07 a.m., CNA 2 held dirty linen with her hands without gloves, placed the dirty linen inside the soiled linen cart, and did not perform hand hygiene. CNA 2 went inside a room (room [ROOM NUMBER]) and did not perform hand hygiene, came out of the room and touched her nose with her fingers and proceeded to walk to a different hallway and did not perform hand hygiene. During an interview on 3/14/20 at 9:11 a.m., CNA 2 stated she provided personal hygiene to a resident (unspecified) and placed dirty linen inside a soiled linen cart. CNA 2 stated she did not wash her hands nor she used hand sanitizer because she forgot. During an interview on 3/15/20 at 11:48 a.m., Registered Nurse 4 (RN 4) stated staff should perform hand hygiene before and after direct contact with the residents to prevent the spread of germs. A review of the facility's policy and procedure titled Handwashing/Hand Hygiene, with a revised date of August 2015 indicated, the facility considered hand hygiene the primary means to prevent the spread of infections. The policy indicated to perform hand hygiene before and after direct contact with residents.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call light button is safe and operable to use for one of 21 sampled residents (Resident 46). This deficient practice had the potential for the resident's needs will not be met timely. Findings: A review of the face sheet for Resident 46, indicated resident was originally admitted to facility on 9/2/17, with [DIAGNOSES REDACTED]. A review of the minimum data set (MDS, a standardized assessment and care planning tool) for Resident 46 dated 1/6/20, indicated Resident 46's cognitive skills for daily decision making was moderately impaired made decisions, and required extensive assistance to total dependent from staff for her activities of daily living. A review Resident 46's Care Plan Communication indicated deficit related to [MEDICAL CONDITION] secondary to injury of the head, approaches plan included use gestures as necessary, reassurance and patience when resident was attempting to communicate. On 3/14/20, at 7:21 a.m., during an initial tour to Resident 46's room, it was observed, call light did not have red button to press. During a concurrent interview and observation with Resident 46, the resident used hand gesture putting the index finger inside the empty whole of the call light and resident pressed it but it didn't work. Resident 46 started banging the side rail to make noise to alert the staff to come over to attend to her need. On 3/14/20, at 10:28 a.m., observed Resident 46 press call light with no red button, then Resident 46 shook side rails to make noise. On 3/14/20, at 10:33 a.m., observed Medical Record and Certified Nurse Assistant 7 (CNA 7) came to Resident 46, during a

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F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) concurrent interview with Medical Record and CNA 7 stated call light had no red button. On 3/14/20, at 10:39 a.m., during an interview with the maintenance supervisor (MS) stated the call light was broken. The facility policy and procedure, titled Maintenance Service Revised December 2009, indicated the maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on interview, and record review, The facility staff failed to respond appropriately regarding types of abuse to be reported to the authority within two (2) hours timeframe as indicated in the facility's policy for 3 of 3 staffs (CNA 3, CNA 8, and DSD). This deficient practice has the potential for the alleged abuse will not be identified immediately and will not be reported to the proper authorities for immediate intervention and legal action. Findings: a. On 3/15/20, at 6:18 a.m., during an interview certified nurse assistant 3 (CNA 3) was asked regarding the ten types of abuse to be reported and the time frame to report the abuse. CNA 3 stated, I don't remember how many types of abuse. b. On 3/15/20, at 6:39 a.m., during an interview with CNA 8, CNA 8 was unable to state all ten types of abuse from the in-service provided by the facility. CNA 8 stated the following types such as: financial, physical, mental, verbal, neglect. c. On 3/15/20, at 6:57 a.m., during an interview, DSD was unable to state all ten types of abuse. The facility policy and procedure, titled Abuse Prevention/Prohibition no date, indicated ten (10) types of abuse: Verbal abuse, Sexual abuse, Physical abuse, Involuntary seclusion, Mental abuse, neglect, Injury of unknown source, Misappropriation of Resident Property, Exploitation, Mistreatment. Staff training reorganizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators. Reporting/Response the facility shall report any and all allegation of abuse to the District CDPH, Local Ombudsman and Local Law enforcement, either by phone, email or facsimile, within 2 hours timeframe.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interview and record review, the facility failed to ensure that all certified nurse aides (CNAs) received at least 12 hours of in-service education per year including abuse prevention and dementia (a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily functioning) management. The facility had no system in place to track the mandatory training and the CNAs in-service education received annually. This failure has the potential for the residents not to receive an appropriate care from a competent and well informed staff. Findings: A review of the facility's list of all current CNAs indicated there were 59 CNAs. During a concurrent interview and record review on 3/15/20, at 4:22 p.m., with Director of Staff Development (DSD), DSD was unable to find a documentation that CNAs' in-service education hours were monitored to comply with the required no less than 12 hours per year including abuse prevention and dementia management. The DSD stated she had no tracking system to monitor all CNAs completed the 12 hours in-services per year as required. DSD stated at this time, she needed to manually check all the sign-in sheets one by one to know if CNAs had at least 12 hours of in-service per year and/or attended the mandatory in-services. DSD stated it was important to comply with the requirement to ensure all staff knew how to provide appropriate care to meet the resident's care needs. A review of the facility's policy and procedure titled, In-Service Training Program, Nurse Aide, dated September 2011, indicated, all nurse aide (NA) personnel shall participate in regularly scheduled in-service training classes. Annual in-service must included: ensure the continuing competence of NAs; be no less than 12 hours per employment year; enhance the skills of the NA in providing care for residents with dementia and preventing resident abuse. All training classes attended by the employee shall be entered on the respective employee's Employee Training Attendance Record .Records shall be filed in the employee's personnel file.