STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056183	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY HEALTHCARE CENTER	1680 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404

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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 interview, and record review, the facility failed to notify the resident and document in the clinical record for one of six sampled residents (Resident 39) when the pain medication order was changed. This failure resulted in Resident 39 not being aware of change of pain medication order which could result in inappropriate pain management. Finding: During a record review of Resident 39's face sheet (a document containing basic information about the resident) indicated Resident 39 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 39's physicians order dated February 25, 2020, indicated, Cut down hydro-codone (a type of pain medication) to 10/325 mg (milligram-a unit of measurement) every 8 hours as needed. During a review of Resident 39's progress notes for the month of February 2020, there is no documented evidence Resident 39 was notified about the change of pain medication order. During an interview with Resident 39 on March 12, 2020 at 4 PM, Resident 39 stated, I was not aware that my pain medication has been changed. I would have liked to know. During an interview with Licensed Vocational Nurse (LVN 4) on March 13, 2020 at 1:38 PM, LVN 4 reviewed Resident 39's progress notes for the month of February 2020, and confirmed there is no documented evidence Resident 39 was notified and documented in Resident 39's clinical record. LVN 4 stated, The nurse should have notified the resident and documented in the chart. During an interview with the Director of Nurses (DON) on March 13, 2020 at 2:25 PM, the DON reviewed Resident 39's progress notes for February 2020 and confirmed there is no documented evidence Resident 39 was notified and documented in Resident 39's clinical record. The DON stated, The nurse should have notified the resident and documented. During a review of the facility's policy and procedure (P&P) titled,Charting and Documentation, undated, the P&P indicated, 1. All observations, medication administered, services performed, etc., must be documented in the resident's clinical record. During a review of the facility's policy and procedure (P&P) titled, Health and Medical Condition, Informing Residents of, undated, the P&P indicated, Resident shall be informed of their total medical condition.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for one of 39 sampled residents (Resident 253) resident 253 medical records were secured to ensure confidentiality. This failure had the potential to allow unauthorized staff or visitors to access resident's confidential medical and personal information. Findings: During an observation on March 9, 2020, at 3:26 PM, at the nurse's station a computer was left opened and logged in to with Resident 253's general progress notes (a medical record where health care professionals record details to document a resident's clinical status) with Resident 253's name, date of birth and medical diagnoses. During a concurrent observation and interview with a Licensed Vocational Nurse (LVN 1), on March 9, 2020, at 3:31 PM, LVN 1 confirmed Resident 253's medical record with general progress notes name, date of birth, and medical [DIAGNOSES REDACTED]. During an interview with the Director of Nursing (DON) on March 12, 2020, at 4:01 PM, the DON stated staff are expected to minimize or drop down the window when they are away from the computer in order to protect the privacy. During a review of the facility's policy and procedure (P&P) titled Confidentiality /Security of Information revised on March 11, 2011, the P&P indicated, All information, both automated and manual regarding specific residents, applicants for admission or related health information pertaining to a resident is protected by law and must be secured against loss, destruction and unauthorized access or use.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an admission Minimum Data Set (MDS- facility assessment tool) assessment was completed according to the Centers of Medicare and Medicaid Services (CMS) timeframes, for one of three sampled residents (Resident 1). This failure had the potential for inadequate monitoring of Resident 1's progress and lack of resident specific information to CMS for payment and quality measure monitoring. Findings: During a review of Resident 1's Face Sheet (contains demographic information) indicated, Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During a concurrent interview and record review with the MDS Nurse on March 13, 2020, at 10:15 AM, reviewed Resident 1's Admission MDS assessment dated [DATE]. The MDS Nurse confirmed Resident 1's Admission MDS assessment was completed on September 24, 2019. The MDS Nurse further stated the Admission MDS assessment should have been completed on September 22, 2019, and submitted in a timely manner. During a review of facility's undated and untitled record indicated, Resident 1's MDS Assessment indicated, Record submitted late. The date is more than 14 days after on this comprehensive assessment. Care plan completed late: For this admission assessment (CAA process signature more than 13 days after the entry date). A further review of the record indicated, Assessment completed late: For this admission assessment completion date is more than 13 days after entry date. A review of CMS's RAI Version 3.0 Manual dated October 2019, page 5-2, indicated, 5.2 Timeliness Criteria: For the admission assessment, the MDS completion date (Z0500B) must be no later than 13 days after the entry date (A1600). During a follow up interview and record review with the MDS Nurse on March 13, 2020, at 11:45 AM, the MDS Nurse reviewed CMS's RAI Version 3.0 Manual dated October 2019, page 5-2, and acknowledged she did not follow the manual and complete the assessment in a timely manner.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a quarterly comprehensive assessment was completed and submitted to the Centers of Medicare and Medicaid Services (CMS) timeframes, for one of three residents (Resident 1). This failure had the potential for inadequate monitoring of Resident 1's progress and lack of resident specific information to CMS for payment and quality measure monitoring. Findings: During a review of Resident 1's Face Sheet (contains demographic information) indicated, Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During a review of facility's undated untitled document indicated, Resident 1's quarterly Minimum Data Set (MDS- a facility assessment tool) assessment with a current target date of December 18, 2019, was completed late. A further review of the record indicated, MDS assessment was submitted late, the date is more than 14 days after assessment. During a concurrent interview and record review, with the MDS Nurse on March 13, 2020, at 11:45 AM, the MDS Nurse reviewed Resident 1's undated untitled document regarding the transmission and submission of MDS data. The MDS Nurse confirmed Resident 1's quarterly assessment was also transmitted late. The MDS Nurse further reviewed CMS's RAI Version 3.0 Manual dated October 2019, page 5-2, and acknowledged she did not follow the manual and complete and transmit the assessment in a timely manner. A review of CMS's

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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 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) RAI Version 3.0 Manual dated October 2019, page 5-2, indicated, 5.2 Timeliness Criteria: -For the other comprehensive MDS assessments, the CAA completion date (V0200B2) must be no later than 14 days from the ARD (A2300).
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS- a facility assessment tool that consists of the resident assessment instrument (RAI) and the care area assessment (CAA)) assessment was conducted and submitted to the Centers of Medicare and Medicaid Services (CMS) within set timeframes, for one of three residents (Resident 1). This failure had the potential for inadequate monitoring of Resident 1's progress and lack of resident specific information to CMS for payment and quality measure monitoring. Findings: During a review of Resident 1's Face Sheet (contains demographic information) indicated, Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During a concurrent interview and record review with the MDS Nurse on March 13, 2020, at 10:15 AM, reviewed Resident 1's Admission MDS assessment dated [DATE]. The MDS Nurse confirmed Resident 1's Admission MDS assessment was completed on September 24, 2019. The MDS Nurse further stated the Admission MDS assessment should have been completed on September 22, 2019, and submitted in a timely manner. During a review of facility's undated and untitled record indicated, Resident 1's MDS Assessment indicated, Record submitted late. The date is more than 14 days after on this comprehensive assessment. Care plan completed late: For this admission assessment (CAA process signature more than 13 days after the entry date). A further review of the record indicated, Assessment completed late: For this admission assessment completion date is more than 13 days after entry date. A review of CMS's RAI Version 3.0 Manual dated October 2019, page 5-2, indicated, 5.2 Timeliness Criteria: -For the admission assessment, the MDS completion date (Z0500B) must be no later than 13 days after the entry date (A1600). For the Admission assessment, the Care area assessment (CAA) completion date (V0200B2) must be no later than 13 days after the entry date (A1600). During a follow up interview and record review with the MDS Nurse on March 13, 2020, at 11:45 AM, the MDS Nurse reviewed Resident 1's undated untitled document regarding the transmission and submission of MDS data. The MDS Nurse confirmed Resident 1's Admission MDS assessment dated [DATE], was submitted late than the required timeframe. The MDS Nurse further reviewed CMS's RAI Version 3.0 Manual dated October 2019, page 5-2, and acknowledged she did not follow the manual and complete and transmit the assessment in a timely manner.
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 accurately code the Minimum Data Set (MDS- facility assessment tool) assessments for one of three residents (Resident 52) when Resident 52's MDS assessment indicated resident had anticoagulants (blood thinners) for seven days. This failed practice had the potential to result in unmet care needs for Resident 52, which can potentially jeopardize health and safety of Resident 52. Findings: During an observation and interview, on March 9, 2020, at 8:30 AM, in Resident 52's room Resident 52 was sitting in her bed watching TV. Resident 52 was alert, oriented and was able to communicate her needs. Resident 52 stated she was not on any blood thinners. During a review of Resident 52's clinical record, Face Sheet (contains demographic information) indicated, Resident 52 was admitted on [DATE], with a [DIAGNOSES REDACTED]. A review of Resident 52's MDS, under Section N- Medications dated January 9, 2020, indicated, Resident 52 received an anticoagulant for seven days from February 2, 2020, to February 9, 2020. During a further review of Resident 52's Physician orders [REDACTED]. During a concurrent interview and record review with the MDS Nurse on March 10, 2020, at 1:47 PM, Resident 52's Physician order [REDACTED]. The MDS Nurse was unable to find a physician order [REDACTED]. A review of the CMS's (Centers for Medicare and Medical Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2019, Page N-7, indicated, N0410E, Anticoagulant: Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, or [MEDICATION NAME] (antiplatelet) here. During a follow up interview and record review with the MDS Nurse On March 10, 2020, at 2:15 PM, the MDS Nurse reviewed CMS's RAI Version 3.0 Manual, dated October 2019, Page N-7, and stated she did not follow the manual. The MDS Nurse further stated she was supposed to ensure the accuracy of their assessments.
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 progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of six sampled residents (Resident 8) physician's order were followed when: 1. Resident 8's physician order for [REDACTED]. to monitor oxygen saturation (the amount of oxygen in the blood) every shift was not being done. This failure had the potential to result in the delay of therapy treatment, and to adversely affect the health and safety of Resident 8. Findings: 1. During a record review of Resident 8's face sheet (a document which contains basic information about the resident), indicated Resident 8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 8's physician order dated March 6, 2020, indicated, Please do ROM exercises to extremities daily times 5 days per week. There is no documented evidence the physician order was carried out and communicated to the RNA. During an interview with the Licensed Vocational Nurse (LVN 4) on March 10, 2020 at 10:38 AM, LVN 4 reviewed the physician's order and confirmed the physician's order was not carried out. LVN 4 stated, It should have been carried out and communicated to the RNA. During an interview with the RNA 1 on March 10, 2020 at 9:45 AM, RNA 1 stated, I have not been doing the ROM because I did not know. I have no record of it. During an interview with the Director of Nurses (DON) on March 10, 2020 at 4:15 PM, the DON reviewed the physician's order and confirmed the nursing staff did not carry out the physician's order for ROM. The DON stated, The order should have been carried out and documented. During a review of the facility's policy and procedure (P&P), titled, Scheduling Therapy Services, undated, the P&P indicated, 2. Therapy is scheduled in coordination with nursing services and is documented in the resident's medical records. 2. During a record review of Resident 8's clinical record, indicated Resident 8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 8's physician order dated November 21, 2019, indicated, Monitor o2 (oxygen) Sat (Saturation-the amount of oxygen level in the blood) Q (every) shift. There is no documented evidence in the clinical record to indicate o2 saturation was being monitor every shift for Resident 8. During an interview with the Licensed Vocational Nurse (LVN 2) on March 11, 2020 at 1:38 PM, LVN 2 reviewed the physician's order and confirmed there is no documented evidence in Resident 8's clinical record to indicate 02 saturation was being monitored every shift. LVN 2 stated, It was not done. During an interview with the Director of Nurses (DON) on March 11, 2020 at 2:15 PM, the DON reviewed the physician's order and confirmed there is no documented evidence in Resident 8's clinical record to indicate o2 saturation was being monitored every shift. The DON stated, The nurses should have done it. During a review of the facility's policy and procedure (P&P) titled, SNF (skilled Nursing Facility) Oxygen Services, undated, the P&P indicated, 1. Check physician orders, and the prescribed liter flow in the resident chart. Further review of the facility's P&P, the P&P indicated, The following should be documented in the resident's chart: monitoring and results observed.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to ensure a licensed staff perform a calibration (to check accuracy) test of the glucometer (device used to check blood sugar) when it malfunctioned during use for one of three sampled residents (Resident 100). This failure had the potential for licensed staff to obtain inaccurate blood sugar readings for Resident 100. Findings: During an observation on March 11, 2020, at 5:20 AM, the Licensed Vocational Nurse (LVN 5) performed a blood sugar check for resident 100, the glucometer did not give a reading. LVN 5 did not calibrate the glucometer after it malfunctioned. LVN 5 continued to check the blood sugar again without recalibration of the glucometer and it did not give a blood sugar reading. During an interview on March 11, 2020, at 6:05 AM, LVN 5 confirmed she did not

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) recalibrate the glucometer after it malfunctioned. LVN 5 stated she never had training for use of the glucometer. During an interview on March 11, 2020, at 6:25 AM, with the LVN 6, LVN 6 stated, I would recalibrate the glucometer if it malfunctions. During an interview on March 11, 2020, at 7:05 AM, with the Director of Nursing (DON), the DON stated, when the machine malfunctions, staff are supposed to get a new machine and then calibrate before use. During a review of the Face sheet (resident general information), Resident 100 was admitted on [DATE], with [DIAGNOSES REDACTED]. During a review of the facility document, Technical Skills Self-Assessment and Orientation Checklist, for LVN 5, dated February 06, 2020, the Technical Skills Self-Assessment and Orientation Checklist, indicated no documentation for glucometer or blood sugar testing. The checklist also indicated that LVN 5 had no opportunity for self-evaluation or re-evaluation of use of a glucometer. During a concurrent interview and review on March 11, 2020, at 9:10 AM, with the DON, the DON reviewed, Record of In-Service Training-Evencare Glucometer, dated June14,2019 and Insulin pens/vials and Accuchecks dated October 2, 2019, LVN 5 was not in attendance. The DON confirmed no other training for staff on glucometer use. During review of manufacturer's guide for Evencare Blood Glucose Monitoring System, the guide indicated, You should perform a control solution test when .You suspect the meter and test strips are not working properly together. During a review of facility's policy and procedure (P&P) titled, Obtaining Fingerstick Glucose Level, revised December 2011, the P&P indicated, Ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or facility.
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 the medication [MEDICATION NAME] (a medication used to treat depression) was available for one out of six sampled residents (Resident 69) when the medication was not available for use. This failure had the potential for Resident 69 not to receive the medication as ordered by the physician. Finding: During a record review of Resident 69's Face sheet (a document with basic information about the resident), indicated Resident 8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 69's physician order [REDACTED]. During a review of Resident 69's medications in the back hall medication cart on March 12, 2020 at 2:47 PM with Licensed Vocational Nurse (LVN 2), the medication [MEDICATION NAME] was not available to be given. During an interview with the Licensed Vocational Nurse (LVN 2) on March 12, 2020 at 3:38 PM, LVN 2 confirmed the medication [MEDICATION NAME] was not available to be given. LVN 2 stated, The medication should be re ordered. The medication should be in the medication cart and it is not. During an interview with the Director of Nurses (DON) on March 12, 2020 at 4:25 PM, the DON reviewed Resident 69's medications and confirmed the medication [MEDICATION NAME] was not available to be given. The DON stated, The medication should be available. During a review of the facility's policy and procedure (P&P) titled,Physician Medication Orders revised on April 2010, the P&P indicated, 9. rugs and biological that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. During a review of the facility's Policy and Procedures (P&P) titled,Administering Medication, revised April 2010, the P&P indicated, Medication shall be administered in a safe and timely manner, and as prescribed.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 ensure safe and sanitary food preparation and storage practices for dietary services when: 1) Plastic pitchers used for food service were not air dried and stored for use. 2) Bowls used for food service were found dirty and stacked for use. 3) The food preparation sink had no air gap and were plumed directly to the waste water system. This had the potential for waste water to enter and contaminate the food preparation sink. These failures had the potential to contaminate resident food sources that can cause foodborne illness (a disease caused by consuming contaminated food or drink), in a vulnerable population of 90 out of 94 residents receiving dietary services, resulting in severe resident harm, and even death. Findings: 1. During an observation and concurrent interview on March 9, 2020, at 8:45 AM, Fifteen out of 20 plastic pitchers were found to be clean and stacked wet for resident used for juice or water, observed with the Dietary Supervisor (DS), The DS stated all dishes and containers should be air dried before being stacked for use. The DS stated if dishes are stacked wet then causes the potential for bacterial growth and a chance of illness to the residents. During a phone interview on March 12, 2020, at 9:10 AM, with the Registered Dietician (RD), the RD stated dishes to include pitchers are clean but stacked wet for resident use it has the potential for bacterial growth due to the moisture and if it were ingested by a resident it could cause the resident to become ill. During a review of the policy and procedure (P&P) titled, Dish Washing, (undated), the P&P indicated, Dishes are to be air dried in racks before stacking and storing. This policy and procedure was reviewed with the DS and confirmed for having the correct content. 2. During an observation and concurrent interview on March 9, 2020, at 8:50 AM, with the DS, two out of 102 bowls were found dirty and stacked for use for resident food. The DS stated the dirty residue on these two bowls could be scraped off with her fingernail and therefore were not clean when stacked for use. The DS stated which created the potential for breeding bacteria which could cause illness to the residents. The DS stated these bowls are used for either cereal or soup for resident consumption. During a telephone interview on March 12, 2020, at 9:10 AM, with the RD, the RD stated if dishes to include bowls that are stacked ready for use and dirty it could cause bacterial growth with the potential to cause illness to the residents, During a review of the policy and procedure for Dish Washing, (undated), the policy and procedure indicated, . food particles shall be removed by careful scraping and pre-rinsing in running water. This policy and procedure was reviewed with the DS and confirmed for having the correct content. 3. During an observation and concurrent interview on March 10, 2020, at 1:20 PM, in the kitchen with Cook 1 and the DS, Cook 1was chopping fruit in preparation for resident consumption at the food prep sink. The DS stated this is the only food preparation sink and the fruit will be served at the dinner meal this evening. During an observation and concurrent interview on March 10, 2020, at 1:20 PM, in the kitchen with both the DS and the Maintenance Director, (MD), the DS and the MD stated there is no air gap under the food prep sink. The MD confirmed the sink is plumed directly to the waste water system. The D.S. stated if there is no air gap under the sink this could cause contamination of bacteria to the residents with the potential to cause illness to the resident from bacteria backing up through the drainage pipe and causing contamination in the kitchen where food is prepared. During an interview on March 10, 2020, at 1:25 PM, with both the DS and MD, they stated they do not have a policy and or procedure regarding the need for air gaps. During a telephone interview on March 12, 2020, at 9:10 AM, with the RD, the RD stated since there is no air gap under the sink used for food preparation it has the potential to cause the backup of the drainage pipe to back up into the sink and contaminate the area including the food and this has the possibility to spread bacteria to the resident and cause them to become sick due to food borne illness. According to the FDA Federal Food Code 2017, During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. Providing an air gap between the water supply and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow.
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 follow their policy and procedure for medication administration when: 1. For Resident 8, nursing staff did not document on the Medication Administration Record (MAR-a record used to document the administration of medications) pain medication was given. 2. For Resident 4 and 33, nursing staff did not document on the MAR the amount of units of insulin (a medication used to treat high blood sugar) was given per thesliding scale (the amount of insulin given based on the blood sugar results) order from the physician. This failure

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) resulted in inaccurate documentation of medication administration which put Residents 8, 4, and 33's health and safety at risk. Findings: 1. During a record review of Resident 8's face sheet (a document which contains basic information), indicated Resident 8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 8's physician order [REDACTED]. During a review of Resident 8's narcotic count sheet, indicated pain medication was administered on March 8, 2020 at 5:40 AM, March 8, 2020 at 12 PM, and March 9, 2020 at 5:40 PM. During a review of Resident 8's MAR for the month of March 2020, there is no documented evidence pain medication administration was recorded in the MAR on March 8, 2020 at 5:40 AM, and March 8, 2020 at 12 PM, and March 9, 2020 at 5:40 PM. During an interview with the Licensed Vocational Nurse (LVN 2) on March 12, 2020 at 2:38 PM, LVN 2 reviewed Resident 8's MAR for the month of March 2020, and confirmed there is no documented evidence pain medication administration was recorded in the MAR. LVN 2 stated, The nurses should have documented. During an interview with the Director of Nurses (DON) on March 12, 2020 at 3:25 PM, the DON reviewed Resident 8's March 2020 MAR, Resident 8's narcotic count sheet and confirmed the nurse did not record pain administration on the MAR. DON stated, The nurses should have documented. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation undated, the P&P indicated, 1. All observations, medication administered, services performed, etc., must be documented in the resident's clinical record. 2. During a review of Resident 4's face sheet (contains demographic information) it indicated Resident 2 was admitted to the facility on [DATE], with the [DIAGNOSES REDACTED].). During record review on March 13, 2020, of the physician's orders [REDACTED]. During a concurrent interview and record review, on March 13, 2020, at 10:37 AM, with the Licensed Vocational Nurse (LVN 2) a review of the MAR for Resident 4, indicated there was no documentation of the amount of insulin units given when following the insulin sliding scale order for Resident 4, for insulin being given on the following dates: March 6, March 8, March 10, March 11 and March 12, 2020. During an interview on March 13, 2020, at 10:37 AM, with LVN 2, LVN 2 stated for Resident 4 she follows the sliding scale and gives the appropriate units of insulin per the sliding scale order according to the blood sugar testing result. During an interview on March 13, 2020, at 11:24 AM, with LVN1, LVN 1 stated the number of units of insulin given per sliding scale order should be documented on the residents MAR. During a concurrent interview and record review done on March 13, 2020, at 2:10 PM, with the Director of Nursing (DON), the DON reviewed and stated the number of units of insulin given per the sliding scale coverage should be documented on the MAR. The DON confirmed the MAR indicated the number of units of insulin given per the sliding scale for Resident 4 was not documented. During a concurrent record review and interview on March 13, 2020, at 2:10 PM with the DON of the facility's policy and procedure titled, Documentation of Medication Administration (undated) indicated Documentation must include: b. Dosage and for Insulin Administration (undated), indicated Documentation - 2. The dose and concentration of the insulin injection. 3. During a review of Resident 33's face sheet it indicated Resident 33 was admitted to the facility on [DATE], with the [DIAGNOSES REDACTED]. During a record review of the physician's orders [REDACTED]. During a concurrent interview and record review with LVN 2 for Resident 33 indicated there was no documentation of the amount of insulin units given per sliding scale for the following dates: March 1, March 2, March 3, March 5, March 6, March 8, March 9, March 10, March 11, March 12 and March 13, 2020. During an interview on March 13, 2020, at 10:37 AM, with LVN 2, LVN 2 stated for Resident 33 she follows the sliding scale and gives the appropriate units of insulin per the sliding scale order according to the blood sugar testing result. During an interview on March 13, 2020, at 11:24 AM, with LVN1, LVN 1 stated the number of units of insulin given per sliding scale order should be documented on the residents MAR. During a concurrent interview and record review done on March 13, 2020, at 2:10 PM, with the Director of Nursing (DON), the DON reviewed and stated the number of units of insulin given per the sliding scale coverage should be documented on the MAR. The DON confirmed the MAR indicated the number of units of insulin given per the sliding scale for Resident 33 was not documented. During a concurrent record review and interview on March 13, 2020, at 11:46 AM with the DON of the facility's policy and procedure titled, Documentation of Medication Administration (undated) indicated Documentation must include: b. Dosage and for Insulin Administration (undated), indicated Documentation - 2. The dose and concentration of the insulin injection.