STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORWALK MEADOWS NURSING CENTER	**10625 LEFFINGWELL ROAD NORWALK, CA 90650**

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 0655 **Level of harm -** 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 develop and implement a baseline person-centered care plan for two of three sampled residents (Residents 1 and 2). Resident 1 was admitted to the facility with perianal (area around the anus) redness with maceration (softening and breaking down of skin from moisture exposure) on left heel ulcer 4 x 4 centimeters ((cm) unit of measurement), right big toe amputated (action of surgically removing a body part), right 2nd toe amputated with open wound 2 x 0.5 x 0.7 cm, right 4th digit toe amputated with open wound 4 x 2 x 1 cm. Resident 2 was admitted to the facility with diabetic ulcers (open sore or wound) on the left and right 5th toes, left anterior 2nd toe, left great toe, left heel, left lower abdomen, and right 5th toe and no groin area redness or ulcers. This deficient practice of not developing a baseline person-centered care plan that would identified the care Resident 1 needed, resulted in Resident 1 not receiving the care and services in a timely manner (within 48 hours following admission per policy and procedures) resulting in the worsening of the initial perianal redness and progressing to a right ischium (curved bone forming the base of the pelvis) Stage III (full thickness skin loss involving damage or necrosis (death skin) of subcutaneous tissue (innermost layer of the skin)) and resulted in Resident 2 to develop redness on her bilateral groin area and had potential for Resident 2's wound to worsen for not having a base-line care plan indicating the care Resident 2 would need to prevent decline of the wounds. Findings: a. A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. (cutting off a limb) of the right great toe. A review of GACH 1's document titled, Patient Transfer Summary, dated 4/1/19 and timed at 3:37 p.m., indicated Resident 1 had Incontinence Associated [MEDICAL CONDITION] ((IAD) irritation to the skin when exposed to urine/stool). A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 4/8/19 indicated Resident 1 had no cognitive impairment (thought process for daily decision making), was able to understand and make herself understood by others. The MDS indicated Resident 1 required extensive assistance of a one-person physical assist for toilet use, personal hygiene, grooming, feeding, bathing, and transferring. The MDS indicated Resident 1 was always incontinent (lack of voluntary control with urination or defecation) of bowel/bladder, had an IAD and was at risk for development of pressure ulcer/injuries. The MDS indicated a pressure reducing device for Resident 1's bed was provided as treatment (sic). A review of Resident 1's admission care plans, there was no baseline center-person care plan found in Resident 1's care plans to identify goals and interventions for perianal redness and excoriation found during the initial assessment conducted on 4/2/19, right heel ulcer 4 x 4 cm, right big toe amputated, right 2nd toe amputated with open wound 2 x 0.5 x 0.7 cm, right 4th digit toe amputated with open wound 4 x 2 x 1 cm. A review of Resident 1's Physician order [REDACTED]. A review of Resident 1's Braden Scale (scale used to identify risk for pressure injury development) dated 4/2/19 and timed at 5:18 p.m. indicated Resident 1 was at mild risk for pressure injury development with a score of 15 (sic) (Severe risk: 9 or less. High risk: 10-12. Moderate risk: 13-14. Mild risk: 15-18). A review of Resident 1's Wound Nurse Body Observation, dated 4/2/19 and timed at 11:21 a.m., indicated Resident 1 had a perianal area redness/excoriated due to episodes of loose stools, left heel ulcer 4 x 4 cm, right big toe amputated, right 2nd toe amputated with open wound 2 x 0.5 x 0.7 cm, right 4th digit toe amputated with open wound 4 x 2 x 1 cm. A review of Resident 1's Change of Condition Assessment ((COC) an internal communication tool), dated 4/3/19 and timed at 7:18 p.m., indicated Resident 1 was noted putting her hand inside her diaper and smearing feces on herself. The COC indicated during an interview with Resident 1, she stated all she wanted was to be changed. A review of an Interdisciplinary Team ((IDT) group of healthcare professional working together toward the resident goals), dated 4/3/19 and timed at 4:11 p.m., indicated the IDT created a treatment plan for Resident 1 to have weekly body checks, physician notification of wound progress, supplemental (vitamins) medication administration and wound consult to promote healing. A review of Resident 1's physician orders, dated 4/8/19 and timed at 3:16 p.m., indicated to administer vitamin supplements to Resident 1 for wound healing. The order indicated Vitamin C (supplement) 500 milligrams (mg) by mouth (PO) every day (QD), Zinc Sulfate (supplement) 220 mg PO QD for 30 days and sugar free pro-stat (protein supplement) 30 milliliters (ML) PO. A review of Resident 1's nurses notes from 4/2019, did not indicate a pressure relieving device was provided on Resident 1's bed and no documented evidence Resident 1's physician was notified of the resident's wound progress and there was no wound consult done as prescribed by the physician. A review of Resident 1's COC Assessment, dated 4/10/19 and timed at 4:03 p.m., indicated Resident 1 complained of discomfort to the buttocks area on 4/10/19. The COC indicated upon assessment of Resident 1's buttocks there was [DIAGNOSES REDACTED] (superficial reddening of the skin because of injury or irritation) around the anal area, scant bleeding, and slight scattered maceration to the skin was noted. The COC Assessment indicated Resident 1's physician was notified on 4/10/19 at 1 p.m., with orders for monitoring, soap and water, pat dry and apply zinc oxide every shift for 21 days and re-evaluate on 5/1/19. A review of the Resident 1's Nurse's Progress Notes from 4/1/19 through 4/10/19, there was no note to indicate Resident 1's wounds were assessed, and/or a wound consult was done, per the IDT's recommendations. On 2/28/2020 at 3 p.m., during an interview and review of Resident 1's nurse's notes in the presence of the Director of Medical Records (DMR), the Assistant Director of Nurses (ADON) stated there was no physician notification of Resident 1's perianal wound maceration from 4/2/19 through 4/9/19 (7days). The ADON stated the initial registered dietitian ((RD) healthcare professionals licensed to assess, diagnose, and treat nutritional problems) recommendations were done on 4/9/19 seven (7) days after admission with orders for [MEDICATION NAME]-vite (combination of B vitamins used to treat or prevent vitamin deficiency) for [MEDICAL CONDITION] residents. The ADON stated there was no initial care plans completed for Resident 1's wounds identified during the resident's initial assessment on 4/2/19. The ADON stated initial care plans are created to identify residents' concerns with staffs' interventions. The ADON confirm there was no pressure reducing device ordered for Resident 1's bed, as per the MDS. On 2/28/2020 at 6:47 p.m., during an interview and review of Resident 1's clinical record and in the presence of the Administrator (ADM), Social Services Director (SSD), the ADON confirmed there was no RD recommendation done upon Resident 1's admission, no pressure reducing devices ordered for Resident 1, who was identified at risk for skin breakdown. The ADM stated RD consults are done within 48 hours of residents' initial admission and initial care plans created upon admission followed by a complete care plan within seven days of admission. On 3/3/2020 at 5:16 p.m., during a telephone interview, Resident 1's physician (Physician 1) stated not being aware of Resident 1's perianal wound. Physician 1 stated an initial wound assessment was conducted to implement a treatment and follow-up assessments of wound's progress. Physician 1 stated the facility should had follow its protocol and IDT interventions for wound treatments. Physician 1 stated it was the facility's responsibility to notify her of new and/or worsening wounds and ensure all staff was aware of care, such as RD and wound consults, pressure reliving devices and supplements were implemented for residents admitted with wounds or at risk for developing wounds. On 3/4/2020 at 1:20 p.m., during an interview and review, the GACH's Director of Compliance

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 0655 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Officer indicated Resident 1 arrived to the GACH on 4/17/19 with a right 4th toe red in color and measurements of 3.5 x 3.5 cm with no drainage, left heel, dry flaky wound measuring 6 x 4 x 0.3 cm, and a right ischium Stage III red-yellowish in color and measuring 3 x 3 cm. The GACH's Director stated the wound pictures were taken on 4/17/19 at 4:40 p.m. On 3/4/2020 at 4 p.m., during a telephone interview, Licensed Vocational Nurse 3 (LVN 3) stated she did not remember Resident 1, but stated initial wound assessments were conducted by the treatment nurse which indicated a full description of the wound and proactive measures used to prevent the wound from worsening or developing new ones. b. A review of Resident 2's Admission Record (Face Sheet) indicated Resident 2 was admitted to the facility on [DATE]. A review of Resident 2's history and physical (H/P), dated 2/23/2020 indicated Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's care plans, there was no baseline care plan for wound treatment found in the clinical record. A review of Resident 2's physician orders, dated 2/22/2020 indicated to treat Resident 2's diabetic ulcers on the left and right 5th toes, left anterior 2nd toe, left great toe, left heel, and right 5th toe with normal saline (salt water), pat dry, apply [MEDICATION NAME] (topical antibiotic used in partial/full [MEDICAL CONDITION] prevent infection) and cover with gauze for 21 days and monitor left lower abdomen discoloration for skin breakdown and discomfort. On 2/28/2020 at 5:50 a.m., during an interview and in the presence of LVN 1, Resident 2 stated the cream on her night stand was given by CNA 2 who told her LVN 2 send her the cream to apply to her buttocks and it was the same cream she used for the wounds on the toes. Resident 2 stated she felt the staff did not care for her because they would not answer her call light at times and would leave her wet. Resident 2 stated she was not checked by the nurse prior to receiving the cream. On 2/28/2020 at 8:40 a.m., during an observation and interview, LVN 6 stated during Resident 2's body assessment, redness to the left and right groin and the buttocks area were noted and where not there before. On 2/28/2020 at 3:31 p.m., during an interview, LVN 2 stated on 2/27/20 she was informed Resident 2 was itching from her buttocks. LVN 2 stated she dispensed zinc oxide (sic) to the resident for her to apply. LVN 2 stated she did not conduct a skin assessment on the resident prior to dispensing the medication nor documented Resident 2 had complained. On 3/4/2020 at 4:11 p.m., during a telephone interview, LVN 4 stated a baseline care plan for Resident 2 was created upon identification of the wound after the initial assessment on 2/27/2020. LVN 4 stated if a resident had a high risk for developing wounds, measures such as a Low Air Loss ((LAL) mattress with tiny air holes that continually blow out air causing the resident to float and prevent ulcers), wound consults, supplements and diet consultations would be implemented. LVN 4 stated baseline care plans are used as guidance for implementations according to the residents needs and to measure the effectiveness of each measured implemented in the resident's care. On 3/5/2020 at 3:48 p.m., during a telephone interview and review with ADON and ADM, the ADON stated Resident 2's base-line care plans were created on 2/28/2020, six days after the initial admission on 2/22/2020. The ADON stated per the facility's Care Plan policy, an initial baseline care plans were done within 48 hours of resident's admission and was used as a guide to provide adequate care to each individual resident. The ADON stated the staff failed to follow the facility's policy. The ADM stated the facility was working on revising all residents' charts to identify those residents with no baseline care plans. A review of the facility's policy and procedure titled, Care Plans-Baseline, revised 12/2016 indicated the facility must develop and implement baseline plan of care to meet the resident's immediate needs within 48 hours of admission. The IDT Team will review the healthcare practitioner's orders (dietary needs, medications, routine treatments) and implement a baseline care plan and be use until the staff can conduct a comprehensive assessment and develop an IDT person-center care plan. The care plan should include initial goals, medications, dietary instructions, and treatments.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**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 ensure residents received the necessary care to prevent pressure ulcers (prolonged pressure on the skin that results in injury to the skin and underlying tissue) from developing and worsening while promoting healing, which included conducting accurate assessments for two of three sampled residents (Residents 1 and 2). (Crossed Reference to F655). For Resident 1, staff failed to develop a person-centered care plan to treat perianal redness and excoriation. The pressure relieving device was not provided. The physician was not notified of Resident 1's wound progress. Resident 1 was not referred to registered dietician upon admission. Resident 1's had to wait 20 minutes and longer for staff to answer her call light. For Resident 2, staff failed to develop a person-centered care plan to prevent the development of skin ulcers. Resident 1 developed a scattered redness of moisture-associated skin damage ((MASD) skin inflammation caused by prolonged exposure to urine, stool, sweat, or saliva) to left/right groin (area between the abdomen and the thigh) and buttocks. These deficient practices resulted in worsening of Resident 1's redness and excoriation of the perianal area which developed into a right ischium (curved bone forming the base of the pelvis) Stage III (full thickness skin loss involving damage or necrosis (death tissue) of subcutaneous tissue). Resident 1 was admitted to the facility with perianal (area around the anus) redness and maceration (softening and breaking down of skin from moisture exposure); and for Resident 2 to develop redness on the groin area. Findings: a. A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. (cutting off a limb) of right great toe. A review Resident 1's GACH document titled, Patient Transfer Summary, dated 4/1/19 and timed at 3:37 p.m. indicated Resident 1 was transfer to the nursing skilled facility (SNF) with a [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 4/8/19 indicated Resident 1 had no cognitive impairment (thought process for daily decision making), and was able to understand and be understood by others. The MDS indicated Resident 1 required extensive assistance of a one-person physical assist for toilet use, personal hygiene, grooming, feeding, bathing, and transferring. The MDS indicated Resident 1 was always incontinent (lack of voluntary control of urination or defecation) of bowel/bladder, had an IAD and was at risk for pressure ulcer/injuries to develop. The MDS indicated a pressure reducing device for Resident 1's bed was provided as treatment (sic). A review of Resident 1's Braden Scale (scale used to identify risk for pressure injury development) dated 4/2/19 and timed at 5:18 p.m. indicated Resident 1 was at mild risk for pressure injury development with a score of 15 (sic). (Severe risk: 9 or less. High risk: 10-12. Moderate risk: 13-14. Mild risk: 15-18). A review of Resident 1's care plans indicated there was no documentation of a baseline center-person care plan for the residents to indicate the facility staffs' interventions to prevent worsening of Resident 1's perianal redness and excoriation. A review of Resident 1's initial assessment conducted on 4/2/19 by the Licensed Nurse indicated the following assessments, heel ulcer 4 x 4 centimeters (cm), right big toe amputated, right 2nd toe amputated with an opened wound 2 x 0.5 x 0.7 cm, right 4th digit toe amputated with open wound 4 x 2 x 1 cm. The initial assessment did not mention a redness to the perianal area and excoriation. A review of Resident 1's Physician Order Report, dated 4/1/19 through 4/17/19 indicated an order with a start date of 4/1/19 for Resident 1's perineal redness with maceration, to be cleansed with soap and water, pat dry and apply zinc oxide (medication to treat and prevent diaper rash) every day and leave open to air for 30 days. A review of Resident 1's Wound Nurse Body Observation, dated 4/2/19 and timed at 11:21 a.m., indicated Resident 1 had a perianal area redness/excoriated due to episodes of loose stools, left heel ulcer 4 x 4 centimeters (cm), right big toe amputated, right 2nd toe amputated with open wound 2 x 0.5 x 0.7 cm, right 4th digit toe amputated with open wound 4 x 2 x 1 cm. A review of Resident 1's Change of Condition Assessment (COC), dated 4/3/19 at 7:18 p.m. indicated Resident 1 was noted putting her hand inside her diaper and smearing feces on herself because she wanted to be changed. A review of an Interdisciplinary Team ((IDT) group of healthcare professionals from different fields who work together toward the same goal for residents), dated 4/3/19 and timed at 4:11 p.m. indicated the IDT treatment plan for weekly body checks, physician notification of wound progress, supplemental medication administration to promote healing, and wound consult for Resident 1. A review of Resident 1's nurses notes did not indicate a pressure relieving device was provided for Resident 1's bed, no physician notification of the resident's wound progress and no wound consult was done, the dietary supplements started on 4/8/19 (7 days after the dietary admission). A review of Resident 1's physician orders, dated 4/8/19 and timed at 3:16 p.m. indicated to administer to the resident the supplements for wound healing. The order indicated Vitamin C (supplement) 500 milligrams (mg) by mouth (PO) every day (QD), Zinc Sulfate (supplement) 220 mg PO QD for 30 days and sugar free pro-stat (protein supplement) 30 milliliters (ML) PO. A review of Resident 1's COC Assessment, dated 4/10/19 and timed at 4:03 p.m., indicated Resident 1 complained of discomfort to the buttocks area on 4/10/19. On assessment, [DIAGNOSES REDACTED] (redness of the skin) around the anal area, scant bleeding, and slight scattered maceration to the skin was noted. The COC indicated Resident 1's physician was notified on 4/10/19 at 1 p.m., with orders for monitoring, cleanse with soap and water, pat dry and apply zinc oxide every shift for 21 days and re-evaluate on 5/1/19. A review of Resident 1' nurses notes from 4/1/19 through 4/10/19, did not indicate a progress note was done for Resident 1's wounds and/or a wound consult was done. On 2/27/2020 at 1:35 p.m., during a telephone interview, Resident 1's Responsible Party 1 ((RP 1) a person designated to make

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) decisions) stated Resident would call her at night telling her the nurses would leave her wet and soil (with urine and stool) all night. RP 1 stated Resident 1 would fall asleep waiting to be changed and wake-up wet and soil. RP 1 stated Resident 1 complained when the nurses did clean her, they would clean her with a rough cloth causing her buttocks area to bleed. On 2/28/2020 at 5:05 a.m., during an initial tour of the facility, call-lights from Rooms 3, 7, 25 and 31 were observed blinking and heard ringing at the nurses' station panel. The staff did not respond to the call light until 5:25 a.m. (20 minutes later). On 2/28/2020 at 3 p.m., during an interview and review of Resident 1's nurse's notes and in the presence of the Director of Medical Records (DMR), the Assistant Director of Nurses (ADON) stated there was no physician notification of Resident 1's perianal wound maceration from 4/2/19 through 4/9/19 (7days). The ADON stated the initial registered dietitian ((RD) healthcare professionals licensed to assess, diagnose, and treat nutritional problems) recommendations were done on 4/9/19 seven (7) days after admission with orders for [MEDICATION NAME]-vite (combination of B vitamins used to treat or prevent vitamin deficiency) for [MEDICAL CONDITION] residents. The ADON stated there was no initial baseline care plan completed for Resident 1's wounds identified during the resident's initial assessment on 4/2/19. The ADON stated initial care plans are created to identify residents' concerns with staffs' iterventions. The ADON confirm there was no pressure reducing device ordered for Resident 1's bed, as per the MDS. On 2/28/2020 at 6:47 p.m., during an interview and review of Resident 1's physician's orders, nurse's notes and RD assessment in the presence of the Administrator (ADM), Social Services Director (SSD), the ADON confirmed there was no RD recommendation done upon Resident 1's admission and no pressure reducing devices ordered for Resident 1, who was identified at risk for skin breakdown. The ADM stated the RD consults are done within 48 hours of resident's initial admission with an initial care plan created upon admission followed by a complete care plan within seven days of admission. On 3/3/2020 at 12:45 p.m., during an interview, the ADM stated there was no wound consult ordered for Resident 1 because of the resident's insurance. The ADM stated the facility's treatment nurse assessed the resident's wounds and documented on the resident's progress notes, but the ADM was not able to locate progress notes regarding Resident 1's wound progress. On 3/3/2020 at 5:16 p.m., during a telephone interview, Resident 1's physician (Physician 1) stated not being aware of the wounds to Resident 1's perianal area. Physician 1 stated an initial assessment was conducted to implement a treatment and to follow up with assessments of the wound progress. Physician 1 stated the facility should had followed their protocol for wound treatments and follow their IDT interventions. Physician 1 stated it was the facility's responsibility to notify her of new and/or worsening wounds to Resident 1 to ensure the staff was aware all care was provided, such as RD and wound consults, pressure relieving devices and supplements were implemented for all residents admitted with wounds or at risk for developing wounds. On 3/4/2020 at 1:20 p.m., during an interview, the GACH's Director indicated Resident 1 arrived to the GACH on 4/17/19 with a right 4th toe red in color and measurements of 3.5 x 3.5 cm with no drainage, left heel with dry flaky wound measuring 6 x 4 x 0.3 cm, and a right ischium Stage III red yellowish in color and measuring 3 x 3 cm. The GACH's Director stated the wound pictures were taken on 4/17/19 at 4:40 p.m. On 3/4/2020 at 4 p.m., during a telephone interview, Licensed Vocational Nurse 3 (LVN 3) stated not remembering Resident 1. LVN 3 stated initial wound assessments were conducted by the treatment nurse which indicated a full description of the wound and proactive measures taken to prevent the wound from worsening or developing. b. A review of Resident 2's Admission Record (Face Sheet) indicated Resident 2 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 2's History and Physical (H/P), dated 2/23/2020 indicated Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's care plans there was no baseline care plan for wound treatment found in the clinical record. A review of Resident 2's physician orders, dated 2/22/2020 indicated to treat Resident 2's diabetic ulcers on the left and right 5th toes, left anterior 2nd toe, left great toe, left heel, and right 5th toe with normal saline (salt water), pat dry, apply [MEDICATION NAME] (topical antibiotic used in partial/full [MEDICAL CONDITION] prevent infection) and cover with gauze for 21 days once a day, and monitor left lower abdomen discoloration for skin breakdown and discomfort. The physician orders did not indicate Resident 2 had groin and buttocks MASD. On 2/28/2020 at 5:30 a.m., during an observation and interview, Resident 2 stated she was admitted to the facility on Friday 2/22/2020 with no wounds on her buttocks. Resident 2 stated the staff would put a diaper on her and tell her to go (urinate and defecate) in the diaper and left soil for 3-5 hours. Resident 2 stated on 2/22/2020 the night of her admission to the facility, she had a bowel movement (feces) in her diaper because nobody attended to her call. Resident 2 stated Certified Nurse Assistant 2 (CNA 2) told her she was bleeding from her buttocks. During the interview, Resident 2 had a medication cup containing a white/shiny topical ointment with a tongue depressor stick in on Resident 2's nightstand unattended. On 2/28/2020 at 5:45 a.m., during an interview, CNA 1 stated at times it takes up to an hour to answer call lights due to the facility being short-staffed. On 2/28/2020 at 5:49 a.m., during an interview and review of Resident 2's Treatment Administration Record (TAR), Licensed Vocational Nurse 1 (LVN 1) stated the white cream on Resident 2's bedside was [MEDICATION NAME] medication. On 2/28/2020 at 5:50 a.m., during an interview and in the presence of LVN 1, Resident 2 stated the cream on her night stand was placed by CNA 2, who told her LVN 2 gave her the cream to apply to her buttocks and it was the same cream she used for the wounds on the toes. Resident 2 stated she felt the staff did not care for her because they would not answer her call light at times and leave her wet. Resident 2 stated she was not checked by the nurse prior to receiving the cream. On 2/28/2020 at 8:40 a.m., during an observation and interview, LVN 6 stated during Resident 2's body assessment, redness to the left and right groin and the buttocks area that was not there before. LVN 6 stated not being aware or having to receive report of Resident 2's skin problems. On 2/28/2020 at 1:23 p.m., during an interview, CNA 2 stated on 2/27/2020 Resident 2 stated having redness and that was itchy on her buttocks area. CNA 2 stated she did not check the resident but did notify LVN 2. CNA 2 stated LVN 2 gave her the cream from the treatment cart to give to the resident to apply. CNA 2 stated not conducting a Stop and Watch (internal document identifying skin problems) form because she did not check the resident and gave the medication for the resident to apply. On 2/28/2020 at 3 p.m., during an interview and review of Resident 2's clinical chart with ADON and the DMR, ADON stated no previous documentation was found of Resident 2's redness to her groin and buttocks area. The ADON stated the RD consult and supplements for wound healing were initiated for Resident 2 late on 2/28/2020 (6 days after admission). The ADON stated medications are not to be given for residents to administer themselves. On 2/28/2020 at 3:31 p.m., during an interview, LVN 2 stated on 2/27/2020 she was informed of Resident 2 itching from her buttocks. LVN 2 stated she dispensed zinc oxide to Resident 2 for resident to apply. LVN 2 stated she did not conduct a skin assessment on Resident 2 prior to dispensing the medication nor did she document Resident 2's complained of new area with itching. LVN 2 stated medications are not to be left at residents' bedside because it can cause harm to the resident if not taken or applied correctly. On 2/28/2020 at 5:35 p.m., during an interview, Resident 2's Responsible Party 2 (RP 2) stated placing a grievance with the facility's Director of Social Services (DSS) regarding Resident 2 being left wet for two hours on the day of her admission on 2/22/2020. RP 2 stated the facility has not called her to explain or respond to her grievance of why Resident 2 was left wet. On 3/4/2020 at 4:11 p.m., during a telephone interview, LVN 4 stated a baseline care plan for Resident 2 was created upon identification of the wound after the initial assessment. LVN 4 stated if a resident had a high risk for developing wounds, measures such as a Low Air Loss ((LAL) mattress with tiny air holes that continually blow out air causing the resident to float and prevent ulcers), wound consults, supplements and diet consultations would be implemented. LVN 4 stated baseline care plans are used as guidance for implementations according to the residents needs and to measure the effectiveness of each measured implemented in the resident's care. On 3/5/2020 at 3:48 p.m., during a telephone interview and review with ADON and ADM, the ADON stated Resident 2's base-line care plans were created on 2/28/2020, six days after the initial admission on 2/22/2020. The ADON stated per the facility's Care Plan policy, an initial baseline care plans were done within 48 hours of resident's admission and was used as a guide to provide adequate care to each individual resident. The ADON stated the staff failed to follow the facility's policy. The ADM stated the facility was working on revising all residents' charts to identify those residents with no baseline care plan. A review of the facility's policy and procedure titled, Pressure Ulcer/Injury Risk Assessment, revised 7/2017 indicated the purpose of the policy was to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries. Risk factors that increase resident's susceptibility to develop or not to heal wounds were impaired/decreased mobility, exposure of skin to urinary and fecal incontinence, [MEDICAL CONDITION], and diabetes. The policy indicated for staff to immediately (no later than 8 hrs. after admission) conduct an assessment to identify risk factors and create resident-centered care plan. The policy indicated a resident-centered care plan with interventions would be created upon identification of a new wound and interventions to be evaluated to identify its effectiveness. A review of the facility's policy and procedure titled, Admission Assessment and Follow-up: Role of the Nurse, revised 9/2012 indicated the purpose of the policy was to guide the facility staff in the gathering of the resident's information for managing the residents' care. The policy indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORWALK MEADOWS NURSING CENTER	10625 LEFFINGWELL ROAD NORWALK, CA 90650

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) staff was to conduct an admission assessment, list all active diagnoses, reconcile the list of all medications from the medication history and admitting orders, contact the attending physician to obtain orders and contact outside services the resident will need.
F 0757 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of unnecessary drugs due to inadequate monitoring of a resident's laboratory levels as prescribed by the physician for one of three sampled residents (Resident 1). Resident 1, who had a left toe osteo[DIAGNOSES REDACTED] (bone infection), was discharged from a general acute care hospital (GACH) on 4/1/19 with an order to receive an intravenous ((IV) into the vein) antibiotic ((ABX) used to treat infections) for two weeks and check the antibiotics lab levels every other day was not implemented. This deficient practices resulted in Resident 1 being transfer to the GACH for low blood pressure and had the potential for Resident 1 to not receive the therapeutic dose (initial dose of 15 milligrams (mg)/kilograms (kg) of body weight) prescribed to treat an infection and placed Resident 1 in a nephrotoxicity (body exposure to an antibiotic or toxin causing damage to the kidneys (two bean-shaped organs that help the body pass waste as urine)) for not checking the antibiotic lab levels. Findings: A review of Resident 1's GACH discharge order, dated 4/1/19 and timed at 1:49 p.m. indicated to discharge Resident 1 to the skilled nursing facility (SNF) and administer 1-gram ((gm) units of measurement) IV [MEDICATION NAME] (antibiotic) with [MEDICAL TREATMENT] (process of removing excess water, solutes, and toxins from the blood) and to check [MEDICATION NAME] levels every other day for two weeks. A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was admitted to the SNF on 4/1/19. Resident 1's [DIAGNOSES REDACTED].(cutting off a limb) of right great toe. A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 4/8/19 indicated Resident 1 had no cognitive impairment (thought process) for daily decision making, was able to understand and make herself understood by others. The MDS indicated Resident 1 required extensive assistance of a one-person physical assist for toilet use, personal hygiene, grooming, feeding, bathing, and transferring. The MDS indicated Resident 1 was always incontinent (lack of voluntary control over urination or defecation) of bowel/bladder, was at risk for pressure ulcer to develop. The MDS indicated pressure reducing device for bed was provided as treatment. A review of the physician order [REDACTED]. A review of Resident 1's laboratory record did not indicate lab levels for [MEDICATION NAME] were done as prescribed by the physician. A review of the revised 9/12/19 DailyMed National Library of Medicine indicated systemic [MEDICATION NAME] exposure may result in acute kidney injury (AKI). Monitor renal function in all patients, especially patients with underlying renal impairment, patients with co-morbidities that predispose to renal impairment, and patients receiving concomitant therapy with a drug known to be nephrotoxic. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f604d399-fded-4f4f-8efe-af558ed07b9d A review of Resident 1's [MEDICAL TREATMENT] record titled, [MEDICATION NAME] Utilization April 2019, indicated Resident 1 received six doses of [MEDICATION NAME] on the following days: 4/2/19, 4/4/19, 4/6/19, 4/9/19, 4/11/19 and 4/13/19 at the [MEDICAL TREATMENT] center. A review of Resident 1 GACH Emergency Department (ED) admission notes, dated 4/17/19 indicated Resident 1 was admitted with low blood pressure. The report indicated Resident 1's range of systolic (top number) blood pressure (SBP) during the first 24 hours of hospitalization were 63-95 and diastolic (bottom number) blood pressure (DBP) of 37-64 (Normal Reference Range (NRR) SBP 139-110 and DBP 80-70). The notes indicated Resident 1 was schedule to have a paracentesis (perforation of a cavity of the body with a hollow needle to remove fluid or gas) on 4/17/19 but was not done due to the resident's low blood pressure. On 2/28/2020 at 3 p.m., during an interview and review of Resident 1's complete clinical record with the Assistant Director of Nurses (ADON) and the Director of Medical Records (DMR), the ADON stated Resident 1's [MEDICATION NAME] lab levels where drawn at the [MEDICAL TREATMENT] center. The DMR stated there was no [MEDICATION NAME] levels found in Resident 1's clinical record. The ADON stated all new admission orders [REDACTED]. On 2/28/2020 at 6:47 p.m., during an interview and review of Resident 1's care plans, laboratory results, IDT's and physician orders, in the presence of the Administrator (ADM), Director of Staff Development (DSD), the ADON stated the [MEDICAL TREATMENT] center was not notified Resident 1 had orders for [MEDICATION NAME] levels to be drawn. The ADM stated the facility's staff was responsible to ensure all admission orders [REDACTED]. The ADM stated she (ADM) felt bad Resident 1 did not receive the care she needed to prevent ulcer from worsening and not having [MEDICATION NAME] levels check. On 3/3/2020 at 11:43 a.m., during an interview, the [MEDICAL TREATMENT] facility's administrator (DFA) stated the facility did not inform the [MEDICAL TREATMENT] Center of the physician's laboratory orders for [MEDICATION NAME]. The DFA stated the center does not draw levels for [MEDICATION NAME] per its company's policy. The DFA stated Resident 1 did receive the six doses of [MEDICATION NAME] but no labs were drawn. A review of the facility's policy and procedures titled, Admission Assessment and Follow-up: Role of the Nurse, revised 9/2012 indicated the purpose of the policy was to guide the facility staff in the gathering of the resident's information for managing the residents' care. The policy indicated the staff was to conduct an admission assessment, list all active diagnoses, reconcile the list of all medications from the medication history and admitting orders, contact the attending physician to obtain orders and contact outside services the resident will need.