STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056127	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIVE OAK REHAB CENTER	537 W LIVE OAK SAN GABRIEL, CA 91776

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy to inform the residents and/or resident's representative and provide with written information concerning the option to formulate an advance directive (a written statement of a person's wishes regarding medical treatment, often including a living will) for three of 20 sampled residents (Resident 54, Resident 89, and Resident 341). This failure had the potential to violate the residents' rights to be informed and be given an opportunity to make decisions about health care. The deficient practice had the potential for the resident to receive unnecessary care and/or treatment against the resident's wishes. Findings: a. A review of an Admission Record indicated Resident 54 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 54 was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. During a concurrent interview and record review on 3/4/20, at 10:26 a.m., Social Service Director (SSD) reviewed Resident 54's medical record and she was unable to find a documented evidence that advance directive (AD) was addressed and if written information concerning the option to formulate an AD was provided to Resident 54 and/or resident's representative (RR). SSD stated the facility used AD acknowledgement form which indicated that resident was informed of the right to formulate an AD and given written materials. SSD stated Resident 54 had no signed AD acknowledgement form. b. A review of an Admission Record indicated Resident 89 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 89's cognitive skills (a mental process of acquiring knowledge and understanding) for daily decision making was severely impaired. Resident 89 was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, personal hygiene, and bathing. During a concurrent interview and record review on 3/4/20, at 1:22 p.m. Social Service Director reviewed Resident 89's medical record and she was unable to find a documented evidence that AD was addressed and if written information concerning the option to formulate an AD was provided to the resident and/or RR. SSD stated, the facility used AD acknowledgement form which indicated the resident was informed of the right to formulate an AD and given written materials. SSD stated, Resident 89 had no signed AD acknowledgement form. c. A review of an Admission Record indicated Resident 341 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE] and completed on 3/5/20, indicated Resident 341's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 341 was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. During a concurrent interview and record review on 3/4/20, at 10:20 a.m., Social Service Director reviewed Resident 341's medical record and she was unable to find a documented evidence that AD was addressed and if written information concerning the option to formulate an AD was provided to the resident and/or RR. SSD stated, the facility used AD acknowledgement form which indicated that resident was informed of the right to formulate an AD and given written materials. SSD stated Resident 341 had no signed AD acknowledgement form. During an interview on 3/4/20, at 9:49 a.m., SSD stated the resident and/or RR should be informed on the option to formulate AD to honor their wishes in case of emergency and it is the resident's right. SSD stated it should be documented. A review of the facility's document, titled, Advance Directives for Care, dated 7/15/16, indicated, residents and families are fully informed on the availability of options for giving all medical care providers advance directives regarding the resident's health care. Pamphlets and documents describing the AD programs and the forms necessary to execute the directives are presented to residents and their families in order to explain the programs. If residents or their families have additional questions regarding the forms and pamphlets provided, they are referred to their physician or attorney for further information.
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 to observation, interview, and record review, the facility failed to provide privacy when providing care to one of 20 sampled residents (Resident 70). This deficient practice had the potential for the resident's right for personal privacy not protected. Findings: A review of the facility's admission record indicated Resident 70 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set ((MDS) dated [DATE] indicated Resident 70 rarely/never understood other or rarely/never made self understood. Resident 70 required total dependence (full staff performance every time) with one person physical assist for bed mobility, dressing and personal hygiene. On 3/3/20 at 8:35 a.m., during a tour observation of the facility and concurrent interview, Resident 70 was lying in bed and Certified Nursing Assistant 1 (CNA 1) was providing care to Resident 70. Resident 70's bed was the first bed next to the door. The privacy curtain for Resident 70 was half closed at one side leaving the other half open to public. CNA 1 stated that she should have fully closed the curtain when providing care to Resident 70. CNA 1 stated it was very important to give privacy to each resident . On 3/6/20 at 11:59 a.m., during an interview, Registered Nurse 1 (RN1) stated, the facility staff should fully close the privacy curtain when providing care to residents. A review of the facility's undated policy and procedure titled Personal Privacy indicated, in order to preserve personal privacy, staff shall keep privacy curtains pulled closed when administering personal procedure (shutting resident's door is insufficient).
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 observation, interview, and record review, the facility failed to provide comfortable room temperature to one of 20 sampled residents (Resident 191). This deficient practice had the potential to result in hypothermia (low body temperature) and adverse (harmful) consequences to the resident's health and well being. Findings: A review of the facility's admission record indicated Resident 191 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set ((MDS) dated [DATE] indicated Resident 191 had clear speech, understood others and made self understood. Resident 191 required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) for transfer and personal hygiene. On 3/3/20 at 8:08 a.m., during an observation and concurrent interview, Resident 191 was sitting in wheelchair having breakfast in her room. Resident 191 stated her room temperature was too low during the night and she was cold. Resident 191 had four blankets on

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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 complete the Minimum Data Set (MDS- a standardized resident assessment and care-screening tool) within 14 days upon admission for one of 20 sampled residents (Resident 341). This failure had the potential for the resident not to receive appropriate treatment and/or services. Findings: A review of an Admission Record indicated Resident 341 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a concurrent interview and record review on 3/5/20, at 10:53 a.m., Registered Nurse/MDS Coordinator (RN 2) reviewed Resident 341's medical record and stated the MDS was not completed. A review of the MDS dated [DATE], indicated in progress. Most of the MDS sections were blank, only section F (preferences for routine and activities) was completed, and there was no section Z (assessment administration/signature of persons completing the assessment). RN 2 stated MDS completion was two days overdue and it should be completed 14 days after admission. A review of the facility's document titled, Resident Assessment, dated (NAME)2014, indicated, the comprehensive assessment shall be used to develop a comprehensive care plan to allow the resident to reach his/her highest practicable level of physical, mental, and psychosocial functioning. Care Area Assessment (CAA) use additional assessment, problem identification and form the final linkage to the care plan. Assessments (admission, quarterly, annual, significant change .) will be completed as per the Resident Assessment Instrument (RAI) instruction/guidelines. A review of the facility's document titled, RAI Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary, dated October 2019, indicated, Admission MDS and CAA completion date no later than 14th calendar day of the resident's admission.
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 interview and record review, the facility failed to address a physician's order for the use of [REDACTED]. This failure had the potential for the resident not to receive interventions to address resident's specific care needs. Findings: A review of an Admission Record indicated Resident 341 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 3/2/20 and completed on 3/5/20, indicated, Resident 341's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 341 was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. A review of Resident 341's physician's order, dated 2/20/20, indicated [MEDICATION NAME] two milligrams (mg) per milliliter (ml) solution give 0.5 mg (0.25 ml) every four hours as needed for anxiety. During a concurrent interview and record review on 3/6/20, at 8:12 a.m., the Director of Nursing (DON) reviewed Resident 341's medical record and she was unable to find a documentation that [MEDICATION NAME] was included in the BCP. DON stated, medication such as [MEDICATION NAME] should be addressed on BCP and implement intervention to meet the needs of the resident. A review of the facility's undated policy and procedure (P&P) titled, Baseline Care Plan, indicated, nursing are required to develop a BCP within 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. Changes and updates will be done on the BCP as needed until a comprehensive care is developed in order to meet resident's ongoing needs.
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 an individualized plan of care, for two of 20 sampled residents (Resident 5 and 51) to : a. Address the use of siderails for Resident 51. b. Address Resident 5's inability to swallow and drink to prevent aspiration (inhalation of food and fluids into the lungs). These deficient practices had the potential for the residents not to receive appropriate care and services based on specific needs. Findings: a. A review of the face sheet for Resident 51, indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 51's Minimum Data Set (MDS, a standardized assessment and care planning tool) for Resident 51, dated 12/25/19, indicated the resident's cognitive skills for daily decision making was severely impaired. Resident 51 required extensive to total dependence from staff for her activities of daily living. A review the physician's orders [REDACTED]. On 3/3/20, at 4:01 p.m., during a tour of the facility with Registered Nurse 1 (RN 1), Resident 51 was observed lying in the bed with four half unpadded siderails up. A concurrent interview with RN 1 indicated Resident 51 had a physician's orders [REDACTED]. RN1 confirmed was no care plan developed for Resident 51 for the use of four half siderails. The review of the facility's undated policy and procedure, titled The Resident Care Plan indicated to provide an individualized nursing care plan and to promote continuity of resident care. b. A review of the admission record indicated Resident 5 was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) a resident assessment and care screening tool, dated 2/10/20, Resident 5 sometimes was able to understand others and express her ideas and wants. Resident 5 required extensive assistance with one person assistance with eating. On 3/3/20 at 11:35 a.m., during a facility tour, Resident 5 was observed coughing after drinking water (non-thickened) from a cup, assisted by family member (FAM 1). In a concurrent interview, FAM 1 stated, Resident 5 was supposed to drink a thickened liquid but the thin liquid (not thickened) was at the bedside. On 3/3/20 at 11:50 a.m., during an interview, Licensed Vocational Nurse 2 (LVN 2) stated, Resident 5 was recently hospitalized due to pneumonia and she was not sure if the resident required to drink thickened liquids to prevent aspiration pneumonia. On 3/3/20 at 12:28 p.m., during an interview, the Director of Nursing (DON) stated, Resident 5 was assessed by Speech Therapist (ST-a health care specialist that assess and evaluates the ability to speak and swallow). DON stated the ST evaluation was ordered on [DATE] due to possible aspiration that resulted to pneumonia. In a concurrent interview, the DON stated, there was no documented evidence that a plan of care was developed that included interventions to prevent aspiration. On 3/3/20 at 1:09 p.m., during an interview with the Speech Therapist, she stated, Resident 5 was assessed for speech and swallow yesterday, 3/2/20. The ST stated she informed the family to monitor Resident 5 and the resident was supposed to be monitored for ability to swallow when eating or drinking. ST stated she informed the staff and the family that was at the bedside yesterday to monitor the resident for ability to swallow when eating and drinking, and for signs of aspiration. A review of the Speech Therapy SLP Evaluation and Plan of Treatment dated, 3/2/20, indicated due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the resident was at risk for dehydration, aspiration, pneumonia and malnutrition.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide feeding assistance for one of 20 sampled residents (Resident 341) who was assessed as totally dependent on staff with one person physical assist for eating. This failure had the potential for the resident not to meet nutritional needs and lose weight. Findings: A review of an

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Admission Record indicated Resident 341 was originally 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 3/2/20 and completed on 3/5/20, indicated Resident 341's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 341 was totally dependent on staff with one person physical assist for activities of daily living (ADLs- bed mobility, dressing, eating, toilet use, personal hygiene, and bathing). A review of Resident 341's Licensed Nurse Record, dated 2/20/20 to 2/27/20, indicated Resident 341 required total assistance with one person physical assist for eating. A review of Resident 341's Resident Care Plan for ADLs Functioning, dated 2/19/20, indicated resident has self care deficit and one of the interventions included to assist with ADLs as needed. A review of Resident 341's Baseline Care Plan, dated 2/20/20, indicated impairment in physical function and the level of assistance needed was total dependence. One of the interventions included was to provide the level of assistance needed. During an observation on 3/3/20 at 12:34 p.m., Resident 341 was eating alone in the room without staff assistance. On 3/5/20 at 8 a.m., in Resident 341's room, the resident was observed with meal tray of puree diet and there was no staff assisting her with eating. During a concurrent interview and record review on 3/5/20, at 10:53 a.m., Registered Nurse/MDS Coordinator (RN 2), reviewed Resident 341's medical record and stated Resident 341 was a total care with one person physical assist for eating. RN 2 reviewed the facility's shift assignment record dated 3/5/20 and stated Resident 341 had no assigned staff for meal assistance. RN 2 stated there should be an assigned staff feeding Resident 341 on every meal to provide the nutritional needs of the resident. A review of the facility's undated policy and procedure titled, Dietary care, indicated, assisting the resident to eat if necessary by nurse assistant.
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 two of three sampled residents (Residents 7 and 89) with pressure ulcer (is a localized damage to the skin and underlying soft tissue over a bony area) by failing to : a. Follow physician's orders [REDACTED]. These failures had the potential for the resident for further skin breakdown. b. Reposition Resident 7 and completely document and sign the Turning And Reposition Schedule Log on 2/15/20, 2/19/20, 2/20/20, 2/21/20, [DATE],and 2/26/2020 on different shifts. There were missing re-positioning documentation on 2/11/20, 2/12/20 and, 2/13/20 for all shifts. These deficient practices had the potential to delay healing of the resident's stage II pressure ulcer. Findings: a. A review of an Admission Record indicated Resident 89 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 2/17/20, indicated Resident 89's cognitive skills (ability to understand) for daily decision making was severely impaired. Resident 89 was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, personal hygiene, and bathing. Resident 89 was at risk of developing pressure ulcer and had pressure ulcers present upon admission. A review of Resident 89's Interdisciplinary Wound Management Care Plan, dated 2/11/20, indicated resident had altered skin integrity manifested by stage 4 pressure ulcer and one of the interventions included to administer treatment per physician (MD) orders. A review of Resident 89's MD order, dated 2/12/20, indicated wound treatment to sacrococcyx pressure ulcer stage 4 to apply Santyl ointment to wound. During a concurrent observation, interview, and record review on 3/5/20, at 9:33 a.m.,Treatment Nurse (TN) 1 applied the Santyl ointment partially on the wound (sacrococcyx pressure ulcer). TN 1 stated it is not necessary to apply the Santyl ointment in the entire wound and she only applied on the slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) of the wound. TN 1 reviewed MD wound treatment order dated 2/12/20 and the order indicated to apply Santyl ointment in the wound. TN1 stated, she should apply the Santyl ointment in the entire wound as ordered by the MD. TN 1 stated if she did not agree with the MD order, it should be clarified and obtain a specific order from the physician. During a concurrent interview and record review on 3/5/20, at 10:12 a.m., Director of Nursing (DON) reviewed Resident 89's MD wound treatment order and stated TN 1 should apply the Santyl ointment to cover the entire wound per MD order. DON stated TN 1 should follow current MD order to treat the wound to prevent any further wound deterioration. DON stated, care plan interventions should be implemented to meet the needs of the resident. A review of the facility's undated policy and procedure (P&P) titled, Pressure Sore Management, indicated, all available measures shall be taken to reduce skin breakdown and pressure sores. If the resident has no treatment orders for the pressure sore(s), an order is to be made. A review of the facility's undated P&P titled, Physician orders [REDACTED]. All orders must be specific and complete with all necessary details to carry out the prescribed order without any questions. A review of the facility's undated P&P titled, The Resident Care Plan, indicated, the resident care plan shall be implemented for each resident. b. A review of the face sheet indicated Resident 7 was admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED].) and collapse and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). A review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) for Resident 7, dated 2/10/20, indicated the resident's cognitive skills (process of acquiring knowledge and understanding) for daily decision making was severely impaired. Resident 7 required total dependence from staff for her activities of daily living with one to two persons assistance for bed mobility and transfer. Section H of the MDS for Bladder and Bowel indicated Resident 7 was always incontinent. Section M of the MDS indicated the resident had unhealed pressure ulcer/injuries stage 2 (partial thickness loss of dermis, presenting as a shallow open ulcer with a red or pink wound bed, without slough) and was placed on turning/repositioning program. A review of the physician's orders [REDACTED]. cover with dry dressing as needed for 30 days; order dated 2/19/20 A review of the Change of Condition (COC)/Interact Assessment Form-(SBAR) for Resident 7, dated 12/15/19, indicated Moisture Associated Skin Damage (MASD) to the sacral area. A review Resident 7's Care Plan for Moisture Associated Skin Damage (MASD) dated on 12/15/19, indicated to reposition and turn the resident every two hours and as needed. On 3/3/20, at 11:49 a.m., during initial tour to of the facility, Resident 7 was observed asleep and lying on her back. On 3/4/20, at 1:10 p.m., during an interview, Treatment Nurse 2 (TN 2) stated Resident 7 should be repositioned side to side every two hours and it should be documented on the Turning And Reposition Schedule Log, signed by the CNA and the Charge Nurse. On 3/4/20, at 1:18 p.m., during an observation with TN2 and RN1, Resident 7 was observed lying on her back. TN2 and RN1 confirmed the resident was lying on her back and not on her side. A review of Resident 7's Turning And Reposition Schedule Log for the month of February 2020 indicated missing pages for 2/11/20, 2/12/20 and 2/13/20. The following days and shifts indicated: - On 2/15/20 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m., there was no position identified for 3-11 shift , there was no signature of Certified Nurse Assistant 3 (CNA 3) and Licensed Vocational Nurse 3 (LVN 3). On 3/5/20 at 9:21 a.m., in a concurrent interview, LVN 5 stated, licensed nurses should check/follow up with CNA on the schedule of repositioning. - On 2/19/20, at 12:00 a.m., 2:00 a.m., 4:00 a.m. and 6:00 a.m., there was no position identified, no signature of CNA 4 and LVN 4. - On 2/20/20, at 6:00 p.m., 8:00 p.m., and 10:00 p.m., there was no position identified, no signature of CNA 3 and LVN 7. - On 2/21/20, at 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., there was no position identified, no signature of CNA 5, and LVN 6 ; For 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m., there was no position identified, no signature of CNA 3 and LVN 6. - On [DATE], at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. there was no position identified, no signature of CNA 4 and LVN 4. - On 2/26/20, at 2:00 a.m., 4:00 a.m., and 6:00 a.m., there was no position identified, no signature of CNA 5 and LVN 4. On 3/5/20, at 9:59 a.m., during an interview, the Director of Nursing (DON) stated, staff must turn/reposition resident every two hours. DON indicated a log was created for turning but there was no facility policy for turning side to side. DON confirmed there were missing signatures in the scheduled log. DON stated, the purpose of turning Resident 7 was to promote wound healing. DON stated, if there was no signature in the log, care was not provided. On 3/5/20, at 5:00 p.m., during an interview, LVN 7, stated she knew Resident 7 needed to be re-positioned every 2 hours and documented and signed in the log but she admitted she forgot to sign the Turning And Reposition Schedule Log for Resident 7. On 3/6/20, at 6:36 a.m., during an interview and record review, CNA 5 stated she forgot to sign the Turning and Reposition Schedule Log for Resident 7. On 3/6/20, at 7:00 a.m., during an interview and record review, LVN 6 stated I don't have an answer why we did not sign the Turning And Reposition Schedule log in February. The log is important because the resident had a wound. LVN 6 stated he didn't realize the facility had the Turning and Reposition Schedule log in February. On 3/6/20, at 7:25 a.m., during an interview and record review, CNA 4 stated Resident 7 can not move by herself and had to be repositioned every two hours. CNA 4 stated From 12:00 a.m. to 2:00 a.m. we turn the resident on her back. On 3/6/20, at 7:40 a.m., during an interview, the Director of Staff Development (DSD), LVN 6, and CNA 4, confirmed that CNA 4 stated he

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) repositioned Resident 7 on her back from 12:00 am to 2:00 am. A review of the facility's undated policy and procedure, titled Pressure Sore Management indicated, the resident is to be re-positioned as scheduled.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents a safe and hazard free environment for three of three sampled residents (Residents 47, 51, and 65). a. For Resident 47, the facility failed to secure the television at the bedside table. b. For Resident 51, the facility failed to provide padded side rails to the resident on [MEDICAL CONDITION] precaution, as ordered by the physician. c. 1. For Resident 65, the facility failed to ensure the personal speaker system was securely placed. The speaker was placed on top of light cover above Resident 65's head of bed. 2. For Resident 65, the facility failed to provide padded side rails to the resident on [MEDICAL CONDITION] precaution. These deficient practices placed the residents at risk for harm and injury. Findings: a. A review of the face sheet indicated Resident 47 was admitted to facility on 8/17/17, with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) for Resident 47, dated 1/21/20, indicated the resident's cognitive skills (process of acquiring knowledge and understanding) for daily decision making was severely impaired and required total dependence from staff for her activities of daily living. A review of Resident 47's care plan for Self Care Deficits and Limitation in Mobility, revised on 5/10/19, indicated interventions to provide a safe environment and to keep the environment free of clutter for safety. On 3/3/20, at 8:51 a.m., during an initial tour to Resident 47's room, the resident was observed lying in bed. A flat screen television was at the resident's bed stand table moving and was unsecured. On 3/3/20, at 9:16 a.m., during an inspection and interview, Housekeeping Supervisor (HKS), confirmed the television was moving on the bed stand table because the strap was loose and the television was on top of the DVD player. HKS stated, the television was unsecured and was not safe and could have fallen causing injury. A review of the facility's undated policy and procedure titled Policy for Resident Having Television In Room indicated maintenance supervisor will strap down television on sturdy bed side table or on top of closet for safety. A review of the facility's undated policy and procedure titled Avoidance of Environmental Hazards indicated the facility will strive to provide a hazard-free environment to ensure that the residents' safety is maintained. The direct care givers (CNA's) will randomly check the resident's unit, with the resident's permission, to identify and/or remove items that may present a risk to the resident's safety. b. A review of the face sheet indicated Resident 51 was admitted to the facility on [DATE], 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 51, dated 12/25/19, indicated the resident's cognitive skills for daily decision making was severely impaired and required extensive to total dependence from staff for her activities of daily living. A review the physician's orders [REDACTED]. On 3/3/20 at 4:01 p.m., during an observation with Registered Nurse 1 (RN1), Resident 51 was lying in bed with all four half siderails up without padding. In a concurrent interview, RN 1 confirmed the side rails were unpadded. A review of the facility's undated policy and procedure titled Accident Reduction: Useful Interventions indicated interventions will be utilized to reduce accidents and injuries. Padding to prevent injuries, e.g., corners of bedside table, etc. c. A review of the facility's admission record indicated Resident 65 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 1/22/20 indicated Resident 65 had clear speech, understood others and made self understood. Resident 65 required supervision (oversight, encouragement or cueing) with setup only for bed mobility, eating and personal hygiene. c.1. On 3/5/20 at 10:17 a.m., during an observation and concurrent interview, there was an unsecured speaker, placed on top of the light cover, above Resident 65's head of bed. Licensed Vocational Nurse 1 (LVN 1) stated, the speaker was not secured to a fixture, easy to fall when there is an earthquake and might hit on the resident's head if she is lying in bed. Resident 65 was observed with mood swings at this time and slightly shook the speaker. The speaker fell into Resident 65's bed. LVN 1 stated, Resident 65 was on antipsychotic medication and Resident 65 had mood swings. The facility administrator (ADM) stated it was dangerous for the speaker placed on top of the light cover over the head of the bed that was not secured. ADM stated there was a potential for injury to the resident if the speaker falls. ADM stated the speaker should be secured to a fixture, maybe into the wall to prevent the possibility of falling down and causing injury to Resident 65. A review of the facility's undated policy and procedure titled Avoidance of Environmental Hazards indicated the facility will strive to provide a hazard-free environment to ensure that the residents' safety is maintained; items that pose harm to residents, due to accessibility by vulnerable residents, will be removed, including sharp objects and other items. The cognitive status of the resident will be considered when considering the risk factors, as well as the medical condition, mood and health treatment (medications); the direct care givers will randomly check the resident's unit, with the resident's permission, to identify and/or remove items that may present a risk to the resident's safety. c.2. A review of the facility's Order Summary Report indicated Resident 65 was prescribed with [MEDICATION NAME] (medication to control [MEDICAL CONDITION] activities) 500 milligrams (mg) one tablet by mouth, two times a day for [MEDICAL CONDITION] disorder. The order was dated 1/15/20. A review of Resident 65's care plan titled [MEDICAL CONDITION] Disorder, initiated 2/5/20, indicated staff will provide padded siderails if indicated. On 3/3/20 at 2:38 p.m., during an observation, Resident 65 was lying in bed with unpadded right side rail up. On 3/5/20 at 10:17 a.m., during an interview, LVN 1 stated Resident 65 was on medication for [MEDICAL CONDITION] disorder and staff should have padded the resident's side rails for prevention of injury in the event Resident 65 will have [MEDICAL CONDITION] activity. A review of the facility's policy and procedure titled Accident Reduction: Useful Interventions indicated useful interventions will be utilized to reduce accidents and injuries; padding to prevent injuries.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nutritional and protein nourishment to one of 20 residents ordered for weight management (Resident 7). This deficient practice had the potential to result in resident's impaired nutritional status. Findings: A review of the face sheet for Resident 7, indicated resident was originally admitted to facility on 1/24/12, and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the minimum data set (MDS, a standardized assessment and care planning tool) for Resident 7, dated 2/10/20, indicated Resident 7's cognitive skills for daily decision making was severely impaired to make decisions, and required total dependence from staff for her activities of daily living with one to two persons assisted bed mobility and transfer. Section H Bladder and Bowel indicated always incontinence. Section M indicated unhealed pressure ulcer/injuries stage 2: partial thickness loss of dermis, presenting as a shallow open ulcer with a red or pink wound bed, without slough, and turning/repositioning program. A review of Resident 7's recapitulated physician's orders [REDACTED]. On 3/4/20, at 1:01 p.m., during an interview and record review, Registered Nurse 1 stated physician ordered for Resident 7, 4 oz sugar free house protein nourishment (HPN) three times a day (TID) between meals, and recommendation of pureed diet CCHO (consistent or controlled carbohydrate diet), nectar thicken liquid, multivitamin, calcium, vitamin D, Sugar Free Pro Stat by mouth 20% to 50%, poor intake. On 3/5/20, at 8:00 a.m., observed CNA 6 assisted Resident 7 to eat breakfast. On 3/5/20, at 8:39 a.m., during an interview Certified Nurse Assistant 6 (CNA 6) stated, Resident 7 had forgotten to swallow, fed her this morning, she ate 50% breakfast pureed egg, juice, oatmeal, bread. Nourishment given at 3-11 shift. On 3/5/20, at 9:21 a.m., during an interview and record review, Licensed Vocational Nurse 5 (LVN 5) stated Resident 7's Medication Administration Record [REDACTED]. There was no documented evidence the nourishment was given to the resident at 8:00 p.m., from 2/16/20 to 2/29/20. On 3/5/20, at 9:59 a.m., during an interview director of nursing (DON) stated the charge nurse gave CNA the nourishment to feed Resident 7. Resident 7's MAR indicated [REDACTED]. No signatures mean the nourishments were not given.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician's order and notify the physician that [MEDICAL TREATMENT] (a procedure to remove fluids and toxins from the blood) was not done as ordered for one of two sampled residents (Resident 345). The facility failed to follow its policy to complete [MEDICAL TREATMENT] communication

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F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) record during [MEDICAL TREATMENT] days and implement care plan interventions. This failure had the potential for the resident to develop complications such as fluid overload, excessive bleeding and/or infection to the access site. Findings: A review of an Admission Record indicated Resident 345 was originally 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 3/4/20, indicated Resident 345's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 345 required extensive assistance (staff provide weight-bearing support) with one person physical assist for bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and bathing. Resident 345 was on [MEDICAL TREATMENT]. A review of Resident 345's physician (MD) order, dated 2/26/20, indicated the [MEDICAL TREATMENT] at left upper arm and [MEDICAL TREATMENT] days on Tuesday, Thursday, and Saturday at 10 a.m. A review of Resident 345's Care Plan for [MEDICAL TREATMENT], dated 2/26/20, indicated resident on [MEDICAL TREATMENT] due to [MEDICAL CONDITION] and with arteriovenous (AV) shunt (connection of artery and vein created by a surgeon used for [MEDICAL TREATMENT] access) on left upper arm. The interventions included post [MEDICAL TREATMENT] to document date, time, and condition of the resident when he/she comes back. During a concurrent interview and record review on 3/4/20, at 3:17 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she received a report on 3/2/20 (Monday) that Resident 345's [MEDICAL TREATMENT] was not done on 2/29/20 (Saturday) as ordered by the MD. LVN 2 reviewed Resident 345's medical record and she was unable to find the documentation on the reason why it was not done on 2/29/20. There was no documentation the MD was notified or MD order to re-schedule the [MEDICAL TREATMENT]. LVN 2 stated staff should follow MD order, it is important to dialyze the resident to remove the waste from the body and MD should be notified if order was not done. LVN 2 reviewed Resident 345's [MEDICAL TREATMENT] communication record dated 3/2/20, there was no [MEDICAL TREATMENT] assessment and on 3/3/20, there was no cognitive status assessment post [MEDICAL TREATMENT]. LVN 2 stated assessment should be done when resident was received post [MEDICAL TREATMENT] to make sure resident in stable condition and the access site was patent and no bleeding. LVN 2 stated assessment should be documented in the [MEDICAL TREATMENT] communication record. LVN 2 stated care plan interventions should be implemented to meet the resident's needs. A review of the facility's undated policy and procedure titled, Care of resident Receiving [MEDICAL TREATMENT], indicated, complete communication record during [MEDICAL TREATMENT] days Facility nurse will complete the record post [MEDICAL TREATMENT]. Complete post [MEDICAL TREATMENT] assessment on return from the treatment. Nursing staff will observed the resident included change on level of consciousness and absence of bruit and thrill (bruit is rumbling sound to hear and thrill is a rumbling sensation to feel to indicate how well the [MEDICAL TREATMENT] access is functioning) of shunt area. A review of the facility's undated P&P titled, The Resident Care Plan, indicated, the resident care plan shall be implemented for each resident .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 341) was free from unnecessary [MEDICAL CONDITION] medications (any drug that affects brain activities associated with mental processes and behavior). Resident 341 was receiving [MEDICATION NAME] (medication to treat anxiety) as needed without a stop date and no informed consent for its use. This failure had the potential to lead to an adverse (harmful) consequences to the resident associated with the unnecessary medication use. Findings: A review of an Admission Record indicated Resident 341 was originally 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 3/2/20 and completed on 3/5/20, indicated Resident 341's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 341 was totally dependent on staff with one person physical assist for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. A review of Resident 341's physician's (MD) order, dated 2/20/20, indicated [MEDICATION NAME] two milligrams (mg) per milliliter (ml) solution give 0.5 mg (0.25 ml) every four hours as needed for anxiety. During a concurrent interview and record review on 3/5/20, at 1:53 p.m., with Registered Nurse/MDS Coordinator (RN 2), RN 2 reviewed Resident 341's medical record and stated there was no informed consent in the chart for the use of [MEDICATION NAME]. RN 2 stated [MEDICATION NAME] MD order on 2/20/20 had no stop date. During an interview on 3/6/20, at 8:12 a.m., Director of Nursing (DON) stated all [MEDICATION NAME] orders should have an informed consent and 14 days timeframe. DON stated after 14 days, resident should be re-evaluated if needed to continue the use of [MEDICATION NAME] to make sure medication was justified for elderly use and resident was free from unnecessary used of this kind of medication. A review of the facility's undated policy and procedure titled, Psychotherapeutic Medications, indicated, initial assessment for antipsychotic drug use will be on or about 14 days of admission. Informed consent will be obtained from physician to administering psychotherapeutic drugs.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medication/medical supply room was free from expired medical supplies for one out of three medication storage rooms. This deficient practice had the potential risk for the residents use of expired medical supplies causing infection. Findings: On [DATE] at 3:05 pm, during an inspection of the facility's medication/medical supply storage room [ROOM NUMBER] with Registered Nurse 1 (RN 1), observed a sealed pack of bladder irrigation set found on top shelf of a locked cabinet indicated an expired date [DATE], and two sealed pack of intravenous tubing set indicated an expired date of ,[DATE]. RN 1 stated did not know why the expired supplies were stocked in this room. RN 1 stated expired medical supply should be removed from storage room to prevent the risk for using on residents. Director of Nursing (DON) stated when medical supplies expired, they become deteriorated or maybe contaminated, may cause infection if used on residents. On [DATE] at 3:59 pm, during an interview, Central Supply (CS) personal stated he was central supply designee, he was responsible for checking storage room [ROOM NUMBER] for expired over the counter medication or supplies, and he checked storage room [ROOM NUMBER] every week for shortage of the over the counter medications and expired supplies. CS admitted he missed to check these expired supplies. CS stated the expired supplies should be removed from the storage room right away. A review of the facility's policy and procedure titled Central Supply indicated .inventorying all supplies on a regular basis to ensure an organized and properly stocked central supply area and monitor expiration dates; check inventory for expired items .
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 and handle food in accordance with professional standard by failing to: a. Label an open date on the opened food container and date and label the food items removed from original package. b. Ensure utensils from the dish rack, clean dishes, and counter was free from contamination. These failures had the potential to cause food contamination and place the residents at risk for food borne illnesses. Findings: a. During a concurrent initial kitchen tour observation and interview on 3/3/20, at 7:46 a.m., with Dietary Aide (DA) 1, observed one opened container of chocolate ice cream in the freezer without an open date label, 15 glasses of white beverages in one tray without label, nine pitchers of variety of juices in the refrigerator without labels (four out of nine pitchers were not dated either), and seven cups of variety of food items in one tray without labels. DA 1

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) stated all food items should be dated and labeled to know when to discard and to identify what they are. b. During a concurrent observation and interview on 3/3/20, at 8:41 a.m., with DA 2, observed DA 2 was the only staff assigned to handle soiled and clean dishes. DA 2 had cellphone on his hand used to light the dish machine temperature gauge. DA 2 placed the cellphone in the clean dishes counter with three trays of clean dishes, opened the dish machine, touched the sanitized utensils rack, and checked the chlorine (chemical to kill bacteria) level of the dish machine without performing hand hygiene. DA 2 stated he should do hand washing prior to handling clean dishes and he should not place his cellphone in the clean dishes counter to prevent cross contamination. During an interview on 3/3/20, at 9:05 a.m., with Dietary Consultant (DC), DC stated all food items not in original package and all opened containers should be dated and labeled for proper food storage and handling. DC stated kitchen staff should wash their hands in warm running water for infection control and cellphone should not be placed in the clean dishes counter to prevent cross contamination. A review of the facility's policy and procedure (P&P) titled, Refrigerator/Freezer Storage, dated 2019, indicated, all items should be properly covered, dated, and labeled. Leftovers will be covered, dated, labeled, and discarded within 72 hours. A review of the facility's P&P titled, Dish Washing Procedures-Dish Machine, dated 2019, indicated, use care in removing utensils from the dish rack in order not to contaminate clean items. To prevent cross contamination, it is recommended that two employees handle dish washing. If only one employee is available to wash and handle clean and soiled dishes, the employee must wash hands thoroughly before handling clean dishes.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an ongoing infection prevention and control program was maintained and implemented: a. Safely use of Personal protective equipment (PPE, is protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) when providing care for Resident 4 on contact isolation (for infections, diseases, or germs that are spread by touching the resident or items in the room, wear a gown and gloves while in the resident's room). Gloves were not covering the sleeves end of gown. b. Resident 140's oxygen tubing's initial date it used was not indicated. c. Follow facility policy and procedure related to [MEDICAL CONDITION] (TB) screening prior to work in the facility to one out of five employees upon hired (CNA2). This has the potential for a possible communicable diseases and or infections can spread to other residents in the facility that could affect the residents already compromised health status and well being. Findings: a. A review of the facility's admission record indicated Resident 4 was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's Minimum Data Set ((MDS) dated [DATE] indicated Resident 4 had unclear speech, rarely/never understood other or rarely/never made self understood. Resident 4 required total dependence (full staff performance every time during entire 7-day period with one person physical assist for bed mobility, dressing and personal hygiene. A review of the facility's Order Summary Report dated 2/27/20 indicated Resident 4 was on contact isolation for CRE (Carbapenem-resistant [MEDICATION NAME] are [MEDICAL CONDITION] that that can cause serious infections and require interventions in healthcare settings to prevent spread) rectal and CRE urine. On 3/4/20 at 8:14 am, during an observation, Certified Nursing Assistant 2 (CNA 2) and Licensed Vocational Nurse 5 (LVN 5) entered Resident 4's room with PPE included gown and gloves. CNA2 and LVN 5 gloves were not covering the end of the sleeves of isolation gown left both staffs' partial skin possible for contacting Resident 4, linen or other contaminated surfaces inside isolation room. LVN 5 stated she was in charge of infection prevention in this facility. LVN 5 stated when putting on PPE, both gloves should fully cover the end of sleeves of gown to make sure no skin was exposed from contacting contaminated areas inside the isolation room. LVN 5 stated correctly wearing PPE can prevent the spread of infection. CNA2 stated her gloves should cover end of gown sleeves for purpose of infection control. A review of the facility's policy and procedure Sequence for Putting on Personal Protective Equipment (PPE) indicated .gloves extend to cover wrist of isolation gown . b. A review of the face sheet for Resident 140, indicated the resident was originally admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. support the body's need for blood and oxygen), and [MEDICAL CONDITION] (irregular and often faster heartbeat). A review of Resident 140's minimum data set (MDS, a standardized assessment and care planning tool) dated 2/10/20, indicated Resident 140's cognitive skills for daily decision making was severely impaired to make decisions, and required total dependence from staff for her activities of daily living with one to two persons assisted bed mobility and transfer. Section H Bladder and Bowel; indicated always incontinence. Section M indicated; unhealed pressure ulcer/injuries stage 2: partial thickness loss of dermis, presenting as a shallow open ulcer with a red or pink wound bed, without slough, and turning/repositioning program. A review of Resident 140's recapitulated physician's orders [REDACTED]. Change nasal cannula/mask as needed, change oxygen tubing PRN, monitor oxygen saturation every shift. A review of the Baseline Care Plan, dated 2/19/20, indicated Resident 140 was on oxygen therapy at 2 L/min via n/c. The nursing intervention included, to observe infection control. On 3/3/20, at 11:02 a.m., during an initial tour Resident 140's oxygen tubing was observed not dated. There was no date indicated the oxygen tubing was initially. During a concurrent interview with the Licensed Vocational Nurse 1 (LVN 1) stated the oxygen tubing was not dated and was important to put date on the oxygen tubing so we would know when to change it. The facility policy and procedure, titled Oxygen Administration no date, indicated the oxygen humidifier should also be changed weekly and as needed. The date, time and initials should be noted on oxygen equipment when it is initially used and when changed. c. On 3/6/20, at 9:57 a.m., during an employee file record review, Director of Staff Development (DSD), stated Certified Nurse Assistant 2 (CNA 2) employee file did not have [MEDICAL CONDITION] screening before providing direct patient care services. CNA 2 was hired on 8/6/19. On 3/6/20, at 10:41 a.m., during an interview with the director of nursing (DON) stated new employees must have TB screening done prior to orientation because we don't want the residents and staff to be exposed to [MEDICAL CONDITION]. The facility policy and procedure, titled Employees Will Be Screened For [MEDICAL CONDITION] no date, indicated all new employees will complete a TB screening questionnaire.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide documented evidence one out of 20 sample residents (Resident 7) was revaccinated with pneumococcal vaccine after five years as indicated in the facility's policy and procedure. This deficient practice had the potential to affect the resident's health and well-being. Findings: A review of the face sheet for Resident 7, indicated resident was originally admitted to facility on 1/24/12, and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of the minimum data set (MDS, a standardized assessment and care planning tool) for Resident 7, dated 2/10/20, indicated Resident 7's cognitive skills for daily decision making was severely impaired made decisions, and required total dependence from staff for her activities of daily living with one to two persons assisted bed mobility and transfer. Section H Bladder and Bowel; indicated always incontinence. Section M; indicated unhealed pressure ulcer/injuries stage 2: partial thickness loss of dermis, presenting as a shallow open ulcer with a red or pink wound bed, without slough, and turning/repositioning program. On 3/4/20, at 1:26 p.m., during an interview and record review, Registered Nurse 1 (RN 1) stated Resident 7 received pneumococcal vaccine on 5/7/14. A concurrent interview with RN 1, she stated, I think every five years pneumococcal vaccine needs to renew. The facility policy and procedure, titled Pneumococcal Immunization no date, indicated as an alternative, based on an assessment and practitioner recommendations, as second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicate or the resident or the resident's legal representative refuses the second immunization.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nurse Assistants (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 CNA in-service education was being performed annually. This deficient practice had the potential for the residents not to receive the appropriate care services and interventions necessary to meet residents' needs as

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F 0947 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) identified in the facility assessment. Findings: On 3/6/20, at 8:09 a.m., during a personnel record review and concurrent interview, the Director of Staff Development (DSD) was unable to provide documented evidence of the CNAs in-service education of at least 12 hours per year as required. The DSD stated there was no tracking system developed to ensure that CNAs had at least 12 hours of in-service education per year including abuse prevention and dementia management. The DSD stated the staffs should be competent to provide care to the the residents and meet their needs. The DSD stated facility had residents with [DIAGNOSES REDACTED]. On 3/6/20, at 10:16 a.m., during an interview, the Director of Nursing (DON) stated facility should have a tracking system to ensure CNAs received at least 12 hours of in-service education per year including abuse prevention and dementia management to make sure CNAs were competent to take care of these residents. A review of an undated document provided by the facility, indicated under staff training/education and competencies that CNA are scheduled of in-services per years elder abuse prevention fall prevention, choking prevention, psychological aspect of aging, dementia , care resident with fragile, fall prevention, biohazard safety, elder abuse prevention, burn out policy and procedures, vital signs pain management, laundry safety, HIPPA confidential. etc., and provided to staff members in order to gain knowledge related to standards of care and competencies that are necessary to provide quality care needed for the given resident population.