STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055861	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OJAI HEALTH & REHABILITATION	**601 N MONTGOMERY ST OJAI, CA 93023**

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

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F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have the consent for [MEDICAL CONDITION] medication (medication capable of affecting the mind, emotions, and behavior) signed by the responsible party for Resident 18. This facility failure has the potential for the responsible party not to make an informed decision regarding the use of the [MEDICAL CONDITION] medication. Findings: Review of the resident 18's clinical record on [DATE] at 10:17 a.m. indicated, Resident 18 has an order for [REDACTED]. The consent for [MEDICATION NAME] is not signed by the resident. The NS acknowledged the consent is missing the signature of the resident. During an interview on 3/13/2020 at 9:39 a.m., the director of nursing (DON) acknowledged resident's consent form was not signed. The DON indicated it should have been signed The facility policy and procedure titled Behavior Management dated 12/31/2015 indicated, whenever an order is obtained for [MEDICAL CONDITION] medication, the licensed nurse verifies that the consent has been obtained.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** Based on interview and record review the facility failed to specify one of sixteen sampled residents (Resident 59's) end of life wishes in the electronic health record. This facility failure had the potential for Resident 59's end of life wishes to not be honored. Findings: During a review of the clinical record on 3/11/20 at 4:03 p.m. for Resident 59 no end of life wishes were specified. During record review and concurrent interview on 3/13/20 at 10:19 a.m. with a licensed nurse (LN 8) Resident 59 did not have a specified code status. LN 8 confirmed Resident 59 did not have designated end of life wishes and should have. During an interview and concurrent record review on 3/13/20 at 11:10 a.m. the director of nursing (DON) confirmed Resident 59's end of life wishes were not in the electronic health record and needed to be as this alerts staff as to what care they provide for Resident 59. The facility policy and procedure titled Advance Directives dated December 2016 indicated resident's end of life wishes must be clearly specified.
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.** Based on observation, interview, and record review, the facility failed to provide two of 16 sampled residents (Resident 4 and 58) with a safe, clean and homelike environment. This facility failure resulted in Resident 4 residing in an unsafe and dilapidated room and Resident 58 witnessing chunks of the shower room ceiling fall on a certified nurse assistant (CNA1). Findings: The facility's policy and procedure titled Environmental Safety and Supervision of Residents,,dated July 2017 indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a concurrent observation and interview on 0[DATE], at 9:18 a.m., with Resident 4, in Resident's room, the walls observed with large areas of gouged, chipped, peeling paint exposing damaged, bare wall behind. One 3-foot x 4-foot area of the wall directly next to pillow area of Resident 4's bed had peeling paint and exposed, chipped wall with a 4-inch x 5-inch chunk of wall chipped off below the window sill. A 2-foot x 4-foot area of ceiling with brown staining and peeling, chipped wall material hanging in pieces directly above Resident 4's bed. There is a 3-foot x 3-foot area directly next to a wall electrical outlet by the ceiling with peeling wallpaper border and chipped, peeling wall material; a television is plugged into this outlet. Resident 4 indicated it feels like the facility doesn't care about residents living in rooms that are broken-down and stated I don't know why the owners don't fix it someone is getting greedy and they don't have to move you out to do it that's what they say but they don't. Man someone got the money. During a concurrent interview and observation on 03/12/20, at 4:27 p.m., with a certified nurse (CNA2), in Resident 4's room, CNA2 confirmed the walls and ceiling in the room had tattered, peeling, chipped areas and confirms resident should not have a room with chipped or torn walls and ceiling. During concurrent interviews and observation on 0[DATE], at 11:55 a.m., with Resident 58, a licensed nurse (LN2) and a certified nursing assistant (CNA3), in the shower room in the south-east area of facility, Resident 58 stated makes me feel gross to take shower because the shower ceiling falls down on the staff every time I take a shower and the tile on the floor is gross - they need to clean it. LN2 confirmed the shower room ceiling was crumbling and stated yes, this place is falling apart. CNA3 confirmed pieces of the ceiling in the shower room fell on their head yesterday while assisting Resident 58 in showering and stated I thought it was a ghost but Resident 58 told me, no its the ceiling falling on you.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in interview and record review the facility failed to ensure accuracy of assessment when: 1. History and physical assessment is incomplete and resident's capacity to decide assessment do not match the facilities record for Resident 18. 2. Inaccurate assessment of restorative nursing services for Resident 5. This facility failure had the potential for inappropriate care planning and interventions for Residents 5 and 18. Findings: 1. The facility policy and procedure titled health Information/Record Manual dated 7/25/2013 indicates the facility will create and maintain health record that in addition to their primary intended purpose of clinical and resident care use, will also serve the business and legal needs that will not be compromised. Review of resident 18's clinical record and concurrent interview with the nursing supervisor (NS) on [DATE] at 10:50 AM indicated resident has a history and physical dated 8/9/2019 signed by the medical doctor (MD). The physical examination area of the form is empty. The history and physical indicated resident 18 does not have the capacity to understand and make decisions. The consent for [MEDICATION NAME] (medication capable of affecting the mind, emotions, and behavior) indicated resident 18 as self-responsible. The face sheet indicated resident 18 is self-responsible. The NS acknowledged the history and physical is incomplete and acknowledge the discrepancy between the MD assessments (resident no capacity to understand and make decisions) and the face sheet and consent (indicating the resident as the responsible party). During an interview on 3/13/2020 at 9:39 AM, the director of nursing (DON) acknowledged the history and physical is incomplete and discrepancy between resident's no capacity to understand or decide and resident

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) being self-responsible. 2. During a review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 243, in the section titled, Data Documentation indicates The timely, thorough, and accurate documentation of facts is necessary when recording client data. If you do not record an assessment finding or problem interpretation, it is lost and unavailable to anyone else caring for the client .the American Nurses Association Nursing's Social Policy Statement (2003) mandate, or require, accurate data collection and recording as independent functions essential to the role of the professional nurse. During a review of Resident 5's physician's orders [REDACTED]. per week as tolerated on 2/12/20 at 10:10. During a concurrent record review and interview on 3/13/20 at 11:10 a.m., with a licensed nurse (LN2), the RNA Weekly (Licensed Staff Attestation of Signature for Resident 5, dated 2/15/20, 2/22/20, 2/29/20, and 3/7/20 indicated A. Resident continues on Restorative Program. II. I have reviewed the Weekly Summary of RNA Activities for this resident and am updated on the Restorative Plan of Care. Further review of the Nursing - Weekly Summary dated 2/15/20, 2/22/20, 2/29/20, and 3/7/20 indicated Cont with RNA program performing AAROM to all extremities and tolerating well. LN2 confirmed Resident 5's RNA services were discontinued on 2/12/20. During a concurrent record review and interview on 3/13/20 at 11:30 a.m., with the director of staff development (DSD), the RNA Weekly (Licensed Staff Attestation of Signature and the Nursing - Weekly Summary dated 2/15/20, 2/22/20, 2/29/20, and 3/7/20 for Resident 5 was reviewed. The DSD agreed the assessments were inaccurate.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) recommendations were implemented for two sampled residents (Residents 18 and 26). This facility failure denied Residents 18 and 26 the opportunity to have the mental health services provided that were recommended by the Department of Health Care Services. Findings: The facility policy and procedure titled, Anti-Psychotic Medication Use/PASRR dated 12/2016 indicated, the interdisciplinary team will complete PASRR screening and the facility will see the State program requirements for specific procedures on the completion of PASRR. 1. Review of resident 18's clinical record on [DATE]20 indicated the resident 18 had a PASRR level one evaluation, the result indicates a need for a level two evaluation. The PASRR level two evaluation was not located in the physical chart or the electronic records. During a record review and concurrent interview with the director of nursing (DON) on 9/13/2020 at 9:39 AM, the PASRR level two was located and indicated recommendations regarding the resident's special needs. The DON indicated the facility was not able to implement the PASRR level two recommendations. 2. During a concurrent interview and record review on 3/13/20 at 9:28 a.m. with the Director of Nursing (DON), the document from the Department of Health Care Services addressed to Resident 26, dated 7/1/19 indicated, Level I screen indicates the need for a PASRR Level II Evaluation. A second document from the Department of Health Care Services addressed to Resident 26, dated 10/8/19 indicated that the Level II PASRR Evaluation, completed 7/8/19 recommended that Resident 26 receive, in part, Psychotherapy/Counseling and Psychiatric Consultation. The DON stated that these services have not been provided, because the facility has not had a psychiatrist or a psychologist on staff. DON stated that the facility recently contracted with a psychiatrist, but Resident 26 has not had a psychiatric evaluation to date.
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** Based on interview and record review, the facility failed to develop and implement a baseline care plan for fall prevention for Resident 29. This facility failure had the potential to result in the resident experiencing falls. Findings: During an interview on [DATE] at 12:34 p.m., Resident 1 stated, I've had a few falls from my chair. I get tired. During a concurrent interview and record review on 3/12/20 at 10:46 a.m. with the Director of Nursing (DON), review of the document titled Fall Risk Observation/Assessment, dated 8/30/19, for Resident 29 indicated, a score of 20 (high fall risk). Review of the care plan revealed, that there was not a baseline care plan present to prevent falls within 48 hours of admission. The DON acknowledged that Resident 29 was identified on admission as being at a high risk for falls, and there had been no care plan created on admission to prevent falls. DON stated, It should have been done, but it wasn't.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Develop, implement and revise a comprehensive care plan for fall prevention for Resident 29. This facility failure resulted in Resident 29 experiencing three falls between 12/17/19 and 1/14/20. 2. Implement the care plan for [MED]gen therapy for Resident 4. This facility failure resulted in Resident 4 not receiving [MED]gen per physicians' order and had the potential to cause [MEDICAL CONDITION] (a below-normal level of [MED]gen in the blood that causes damage to vital organs of the body.) Findings: 1. During a review of the facility's policy and procedure titled, Fall Risk Assessment, dated 03/2018, the policy indicates in part, The staff and attending physician will collaborate to identify and address modifiable risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. During a review of the facility's policy and procedure titled, Assessing Falls and Their Causes, dated 03/2018, the policy indicates in part, When a resident falls, the following information should be recorded in the medical record .Completion of a falls risk assessment .appropriate interventions taken to prevent future falls. During a concurrent interview and record review on 3/12/20 at 10:46 a.m. with the Director of Nursing (DON), review of the document titled Fall Risk Observation/Assessment, dated 8/30/19, for Resident 29 indicated a score of 20 (High Risk). Review of the care plan revealed that there was not a comprehensive care plan present to prevent falls. The DON acknowledged that Resident 29 was identified on admission as being at a high risk for falls, and there had been no comprehensive care plan created to prevent falls. DON stated, It should have been done, but it wasn't. DON also confirmed that the falls risk assessment performed on 8/30/18 in Resident 29's medical record was the only falls risk assessment present. During a review of the documents titled, SBAR Communication Form, dated 12/17/19, 1/3/20 and 1/14/20, the situation that was identified was, Falls. 2. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. During a review of the Admission Record for Resident 4, dated 12/6/18, the Admission Record indicated, Resident 4 had [DIAGNOSES REDACTED]. During a review of Resident 4's Care Plan, dated 12/7/18, the Care Plan indicated Resident 4 has altered respiratory status/Difficulty Breathing r/t Acute and [MEDICAL CONDITION] , Primary [MEDICAL CONDITION] Hypertension, Sleep Apnea. A Care Plan intervention indicated, Provide [MED]gen as ordered: continuous [MED]gen at 1 LPM (liter per minute) via NC (nasal cannula) to keep O2 saturation above 88% per MD. (CO2 retention) During a concurrent observation and interview on [DATE] at 9:06 a.m., with Resident 4 and a certified nursing assistant (CNA4), Resident 4 observed lying in bed and an [MED]gen concentrator (medical device used for delivering [MED]gen) was on the right side of the bed with the [MED]gen tubing and nasal cannula (part of the tubing placed in the nose to administer the [MED]gen) lying on top of the [MED]gen concentrator. The [MED]gen concentrator turned off. The [MED]gen tubing labeled with a white piece of tape and dated [DATE]. Resident 4 stated stated I haven't used it in about a week. CNA4 indicated, unsure if Resident 4 should be using [MED]gen. CNA4 further confirmed the [MED]gen tubing was dated [DATE] and should have been changed on a weekly basis. During a concurrent observation, interview and record review on 3/13/20 at 10:13 a.m, with licensed nurse (LN4), and the director of nursing (DON). Resident 4 observed in room, asleep in wheelchair and not on [MED]gen. LN4 indicated unsure if

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure physician orders [REDACTED]. 2. Ensure physicians' orders were followed and documentation was accurate and complete for Resident 4. This facility failure resulted in the resident not receiving [MED]gen and [MED]gen tubing not being changed per physicians' orders, predisposing Resident 4 to [MEDICAL CONDITION] (a condition in which the body is deprived of adequate [MED]gen supply). Findings: 1. According to Potter and Perry 7th Edition, Mosby's Fundamentals of Nursing, page 336, in the section titled, Physicians' Orders indicated, Nurses follow physicians' orders unless they believe the orders are in error or harm clients. Review of the clinical record for Resident 18 indicated [DIAGNOSES REDACTED]. Oxygen levels were not checked and [MED]gen was not administered to Resident 18. Resident 18 was sitting up in room in wheelchair with noted confusion. During record review and concurrent interview on 3/12/20 at 3:44 p.m. LN 7 was shown the physician orders, dated 12/[DATE]9, to check Resident 18's [MED]gen level every shift and to administer [MED]gen if below 88%, LN 7 stated not being aware these orders even existed and had not ever checked Resident 18's [MED]gen level. LN 7 then stated he should have checked Resident 18's [MED]gen level and administered [MED]gen per physician order [REDACTED]. 2. During a review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 336, in the section titled, Physicians' Orders indicated, Nurses follow physicians' orders unless they believe the orders are in error or harm clients. During a review of Resident 4's Admission Record, dated 12/6/18, the Admission Record indicated, Resident 4 had [DIAGNOSES REDACTED]. During a review of Resident 4's Order Summary Report, dated 12/12/18, the Order Summary Report, indicated continuous O2 ([MED]gen) at 1 liter per minute via nasal cannula to keep O2 saturation above 88% per M.D. (CO2 retention) every shift for [MEDICAL CONDITION] (condition in which the body doesn't have adequate [MED]gen). Further, the Order Summary Report, dated 12/27/18, indicated, change O2 tubing weekly on Wednesdays and as needed. During a concurrent observation and interview on [DATE] at 9:06 a.m., with Resident 4 and a certified nursing assistant (CNA4), Resident 4 observed lying in bed and an [MED]gen concentrator (medical device used for delivering [MED]gen) was on the right side of the bed with the [MED]gen tubing and nasal cannula (part of the tubing placed in the nose to administer the [MED]gen) lying on top of the [MED]gen concentrator. The [MED]gen concentrator turned off. The [MED]gen tubing labeled with a white piece of tape and dated [DATE]. Resident 4 stated stated I haven't used it in about a week. CNA4 indicated, unsure if Resident 4 should be using [MED]gen. CNA4 further confirmed the [MED]gen tubing dated [DATE] and are usually changed weekly. During a concurrent observation, interview and record review on 3/13/20 at 10:13 a.m., with licensed nurse (LN4), and the director of nursing (DON). Resident 4 observed in room, asleep in wheelchair and not on [MED]gen. LN4 indicated unsure if Resident 4 should be on [MED]gen. LN4 reviewed Resident 4's physician's orders [REDACTED]. The DON confirmed licensed nursing staff not following physicians' orders and staff not accurately documenting Resident 4's [MED]gen usage.
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.** Based on observation, interview, and record review the facility failed to provide Resident 27 with personal grooming needs. This facility failure resulted in unclean nails. Findings: During an observation on [DATE] at 12:06 p.m. Resident 27 was noted up in wheelchair with finger nails covered in brown/black substance. During record review and concurrent interview on 3/13/20 at 9:51 a.m. a licensed nurse (LN 8) indicated the comprehensive assessment, dated 1/6/2020, for Resident 27 indicated he required extensive assistance of one person for personal hygiene, including cleaning of nails. During an interview on 3/13/20 at 2:24 p.m. a licensed nurse (LN 4) confirmed Resident 27's finger nails were unclean, that Resident 27 required assistance for personal hygiene, and should have had a CNA help him clean his nails. During an interview on 3/13/20 at 2:27 p.m. a certified nurse assistant (CNA 6) saw Resident 27's finger nails and stated yes we are supposed to help him with cleaning his nails, should have been done on Sunday. The facility policy and procedure title Activities of Daily Living (ADLs), Supporting dated March 2018 indicated Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Provide Resident 29 with treatment for [REDACTED]. This facility failure had the potential for delayed healing, infection, and pain. 2. Ensure that a medication, [MEDICATION NAME] 400mg (an anti-epileptic drug, also called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of [MEDICAL CONDITION] and some types of pain), was safeguarded and administered in a safe manner for Resident 26. This facility failure had the potential for Resident 26 to be improperly dosed with [MEDICATION NAME], or for another resident to ingest the medication accidentally. Findings: 1. During an observation on [DATE] at 11:50 a.m. Resident 29 complained of skin abrasion to right lower leg. Resident 29 pulled up the bottom portion of his pant leg and revealed a laceration to the right shin. During record review and interview on 3/13/20 at 10:03 a.m. a licensed nurse (LN 8) stated there are no orders for this leg abrasion (Resident 27) nothing is being done for it, no assessment either care plan, the nurses should have done an SBAR (an assessment tool nurses use to facilitate prompt and appropriate communication for resident treatment needs) for this but none was done. During an interview on 3/13/20 at 10:42 a.m. the licensed nurse (LN 4) assigned to Resident 27 indicated no change of condition or SBAR was done for Resident 27. During an observation and concurrent interview on 3/13/20 at 11:29 a.m. LN 4 saw the laceration to Resident 27's right shin and stated that he had not done anything about it. 2. During a review of the facility's policy and procedure, dated 04/2019, the policy indicates in part, Medications are administered in accordance with prescriber orders, including any required time frames. The policy also indicates, Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. During a concurrent observation and interview on [DATE] at 10:37 a.m., with Registered Nurse (LN1), a medication cup containing [MEDICATION NAME] 400mg was noted on the over-the-bed table of Resident 26 in room [ROOM NUMBER]-B. When asked, Resident 26 stated that the night shift nurse gave it to her at 5:30 a.m., but, I don't like to take it until I get my [MEDICATION NAME] (a narcotic-like pain reliever, [MEDICATION NAME] is used to treat moderate to severe pain in adults). When asked if leaving a medication with a resident to take at a later time is acceptable practice, LN1 stated, no. During an interview on 3/11/20 at 12:08 p.m. with the Director of Nursing (DON), the DON stated that the medication should not have been left at bedside, and that Resident 26 does not have a physician's orders [REDACTED]. The document did not indicate that Resident 26 may self-administer medications.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff applied one of 16 sampled residents (Resident 262's) wound dressing per physician's orders [REDACTED]. Findings: Review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicates, Nurses are obligated to follow physician order [REDACTED]. During a review of Resident 252's Admission Record, dated 3/7/20, the Admission Record indicated, a [DIAGNOSES REDACTED]. During a review of Resident 262's Wound Care Consult, dated [DATE], the Wound Care Consult indicated, the recommended dressing Cleanse: NS, Wound: [MED], Cover: Dry Dressing, Foam dressing with a frequency of QD (every day), + PRN (as needed) Saturation/Soiling. During an observation on 0[DATE], at 10:29 a.m., in

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Resident 262's room, the resident lying in bed, left leg from calf down had black and bluish discoloration. The bottom of the foot had reddish/brownish discharge. A 4 inch x 4 inch thin guaze dressing was on the bottom of the foot; it was soiled with reddish /brownish discharge and only connected by the lower left corner of the dressing. When Resident 262 moves the foot, the dressing flops around not covering the wound. Resident 262 observed moving the foot on the floor, bed, and on lower metal areas of the overhead bed table. During a concurrent observtion and interview on 03/11/20, at 12:41 p.m., with the director of nursing(DON), the physician's orders [REDACTED]. The DON confirmed Resident 262's wound order indicated the use of a foam dressing and not a gauze dressing. The DON further confirmed the gauze dressing was hanging by a thread and is not covering the wound at all and needed changing.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observation, interview, and record review, the facility failed to accurately complete the Multipurpose Drug Dispositions Record Book with date and disposal methods. This facility failure had the potential for loss of medications and diversion. Findings During a review of the facility policy and procedure titled, Discarding and Destroying Medications, dated April 2019, indicated, Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals hazardous waste and controlled substances.11. The medication disposition record will contain the following information: .b. Date medication disposed.f. Method of disposition. During a concurrent interview, and record review, on 3/12/20, at 9:19 a.m., with a licensed nurse (LN6), in the nursing station, the Multipurpose Drug Dispositions Record Book was reviewed. The Multipurpose Drug Dispositions Record Book did not document dates medications disposed of or disposal methods for December 2019 and January 2020. LN6 confirmed the pages for December 2019 and January 2020 in the drug disposition book should be completed with dates or disposal methods and are not.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a medication error rate did not reach five percent or greater. Medication error rate was 7.41%. This facility failure had the potential for adverse medication side effects, adverse reactions, and health complications. Findings: According to AMN Healthcare Education services (https://www.rn.com/nursing-news/safe-medication-administration/) nurses are responsible for administering the correct dose and the full dose of medication to the resident as perscribed in the physician order. During an observation of medication administration on 3/12/20 beginning at 8:53 a.m. a licensed nurse (LN 7) administered [MEDICATION NAME] (liquid medication to prevent [MEDICAL CONDITION] and or treat a [MEDICAL CONDITION] disorder) 10 mililiters (mls) to Resident 18. LN 7 then left a cup with 240 mls of water with [MEDICATION NAME] (powder medication mixed with liquid to prevent constipation) 17 grams (gms) on the bedside table of Resident 18, told Resident 18 to drink it, and immediately left the room without ensuring Resident 18 took the [MEDICATION NAME]. During a review of the clinical record for Resident 18 on 3/12/20 the record indicated [DIAGNOSES REDACTED]. During a review of the clinical record for Resident 18 the Order Summary Report indicated MEDICATION ORDERS FOR [REDACTED]. During a record review and concurrent interview on 3/12/20 3:44 p.m. LN 7 confirmed he left the [MEDICATION NAME] with Resident 18 and should not have done that, LN 7 stated I should have stayed and made sure he drank all the [MEDICATION NAME]. LN 7 further stated Yes the physician order [REDACTED].
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Resident 18 was free of a significant medication error when a licensed nurse (LN 7) administered the wrong dose of [MEDICATION NAME] (medication for [MEDICAL CONDITION] disorders that affects the brain). This facility failure had the potential for Resident 18 to suffer somnolence, agitation, aggression, depressed level of consciousness, respiratory depression, and coma. Findings: During an observation of medication administration on 3/12/20 beginning at 8:53 a.m. a licensed nurse (LN 7) administered [MEDICATION NAME] (define) 10 milliliters (mls) to Resident 18. During a review of the clinical record the Order Summary Reported dated for March 2020 indicated [DIAGNOSES REDACTED]. During a review of the clinical record for Resident 18 the physician orders [REDACTED]. During a record review and concurrent interview on 3/12/20 3:44 p.m. LN 7 confirmed he left the [MEDICATION NAME] with Resident 18 and should not have done that, LN 7 stated I should have stayed and made sure he drank all the [MEDICATION NAME]. LN 7 further stated Yes the physician order [REDACTED].nlm.nih.gov/dailymed/drugInfo.cfm?setid=c6d5784d-abf9-45fe-ac5a-d5c53bd50f7e) giving too much [MEDICATION NAME] has and can result in cases of somnolence, agitation, aggression, depressed level of consciousness, respiratory depression, and coma.
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 date three multi-dose [MED] vials on one of two sampled medication carts. This facility failure had the potential for residents to receive expired [MED] which could lead to life-threatening complications of diabetes. Findings: The United States Pharmacopeia (USP) General, Chapter 797 (16) recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. During a review of the facility's policy and procedure titled [MED] Administration, dated [DATE], indicated, To provide guidelines for the safe administration of [MED] to residents with diabetes.Steps in the procedure ([MED] injections via Syringe).4. Check expiration date, if drawing from an opened multi-dose vial. During a concurrent observation and interview on [DATE], at 11:06 a.m., with a licensed nurse (LN7), three out of five [MED] vials on medication cart currently in use for residents not dated with an open date. LN7 confirmed the three opened vials did not have the required expiration date as this type of [MED] will expire 28 days after opening.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** Based on observation and interview, the facility failed to ensure dietary staffs washed hands and changed gloves between handling contaminated items and clean serving plates or food served to residents. This failure had potential to cause cross-contamination (transferring disease causing germs) from soiled hands to food provided to all residents at the facility, exposing them to the risk of suffering from foodborne illnesses. Findings: During an observation on 3/11/ at 11:40 AM, a dietary staff (DS1) was cooking vegetables on the stove, DS1 went to the trash bin to throw away used paper wrapping. DS1 opened the trash lid with her gloved hand and threw the paper in the bin. DS1 did not remove the gloves and wash her hands and put in new gloves when DS1 went back to the stove. During an observation on 3/11/2020 at 12:10 PM, a dietary staff (DS2) was making sandwiches, after making the sandwiches DS2 went out of the kitchen to the dry storage to get a resealable bag. When DS2 got back to the kitchen, DS2 placed the sandwiches into the bag without washing his hands. During an observation on 3/11/2020 at 12:15 PM, DS1 was putting clean plates to the plate holder during tray line. A plate holder fell on the floor. DS1 picked the plate holder off the floor and placed it on the sink, DS1 then went back to putting clean plates on the plate holder without washing hands and changing gloves. The facility policy and procedure titled Hand Washing and Glove Use dated 2014 indicated in part, each employee will wash his or her hands frequently to eliminate visible dirt or reduce bacterial load . when to wash, between working with raw foods and ready to eat foods . after handling or removing trash . anytime hands are soiled .between glove changes . between any dirty to clean task . gloves will be used in such manner as to prevent food contaminations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055861	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OJAI HEALTH & REHABILITATION	601 N MONTGOMERY ST OJAI, CA 93023

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 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations and interview the facility failed to store food under safe sanitary condition. This facility failure had the potential to cause food borne illness. Findings: During an observation and concurrent interview with the dietary staff (DS1) on [DATE]20 at 8:53 AM, two opened container of spices on the spice rack was not labeled with an open date. DS1 acknowledged the opened containers of spices does not have an open date. During an interview on [DATE]20 at 9 AM, DS 1 acknowledged two open container of spices were not labeled with an open date. The facility policy and procedure titled Food Storage dated 2014 indicates all open and partially used foods shall be dated, labeled and sealed before being returned the storage area.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 implement basic infection prevention when: 1. A nourishment tray contained an open container of yogurt which had dripping yogurt into the holding ice. 2. A wall mounted soap dish in a resident room shower was crusted with dried, caked, and white colored material. 3. An Oxygen concentrator (medical device used for delivering [MED]gen) with humidifier (used to provide moisture during [MED]gen therapy) and tubing was unlabeled and undated for Resident 162. 4. The [MED]gen tubing for Resident 4 was not changed per facility policy and physicians' orders. 5. Resident 262's wound dressing was not properly applied. These deficient practices had the potential for cross contaminations and spread of infections to residents, visitors and staff. Findings 1. According to the FDA (Food and Drug Administration) Food Code 2017, Packaging must be appropriate for preventing the entry of microbes and other contaminants such as chemicals. These contaminants may be present on the outside of containers and may contaminate food . During a concurrent observation and interview on [DATE] at 10:49 a.m., with a certified nursing assistant, (CNA1) at the nourishment cart outside room [ROOM NUMBER], a 32 ounce container of strawberry yogurt was resting in an ice container. The container had an open lid and yogurt noted around the lip of the container and dripping down the side into the ice. CNA1 stated it should not be like that. I should have wiped the sides and closed it. During an interview on 3/13/20 at 10:15 a.m., with the director of nursing (DON), the DON agreed the yogurt container was should have been wiped and closed. 2. According to the APSIC Guidelines for environmental cleaning and decontamination dated 12/29/15, indicates Hospital Clean is a measure of cleanliness routinely maintained in care areas of the health care setting.Bathroom fixtures including toilets, sinks, tubs and showers are free of streaks, soil, stains and soap scum. During an observation on [DATE] at 8:53 a.m., in the bathroom of a multi-resident room, the wall mounted soap dish in the shower stall had crusted, dried, caked, and white colored material build up. During an interview on [DATE] at 9:00 a.m., a licensed nurse (LN1) stated, that is awful. During an interview on 3/11/20 at 2:32 p.m., the director of staff development (DSD), the DSD confirmed the soap dish needs cleaning. During an interview on 3/13/20 at 10:15 a.m., the director of nursing (DON), the DON agreed that the shower soap dish had not been cleaned in quite some time and should have been. 3. During a review of the facility's policy and procedure titled, Prevention of Infection Respiratory Equipment, dated 11/11, indicated The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment.Store the circuit in plastic bag, marked with date and resident's name. During an observation on [DATE] at 9:21 a.m., in Resident 162's room, an [MED]gen concentrator with an attached humidifier and tubing was not labeled with the resident's name or a date. During an interview on [DATE] at 10:05 a.m., with a licensed nurse (LN1), LN1 stated since the [MED]gen had not yet started on Resident 162, there was no need to label the equipment with a name and date. 4. During a review of the facility's policy and procedure titled, Prevention of Infection Respiratory Equipment, dated 11/11, indicated The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff.4. Change the [MED]gen cannula and tubing every seven (7) days or as needed.Store the circuit in plastic bag, marked with date and resident's name. During a review of the Order Summary Report, dated 12/2718, the Order Summary Report, indicated change O2 tubing weekly on Wednesdays and as needed. During a concurrent observation and interview on [DATE] at 9:06 a.m., with a certified nursing assistant (CNA4), Resident 4's [MED]gen tubing and nasal cannula (part of the tubing that is placed in the nose to administer the [MED]gen) was labeled with a white piece of tape and dated [DATE]. CNA4 further confirmed the [MED]gen tubing was dated [DATE] and should be changed weekly. 5. A review of the facility's policy and procedure titled, Infection Control Guidelines for All Nursing Procedures, dated 8/12, indicated, To provide guidelines for general infection control while caring for residents.1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. During a clinical record review of Resident 252's Admission Record, the Admission Record indicated, a [DIAGNOSES REDACTED]. During a clinical record review of Resident 262's Care Plan for [DIAGNOSES REDACTED], dated [DATE], the Care Plan indicated Maintain universal precautions (another term for standard precautions) when providing resident care. During an interview on 0[DATE], at 10:29 a.m., in Resident 262's room, the resident lying in bed, left leg from calf down had black and bluish discoloration. The bottom of the foot had reddish/brownish discharge. A 4 inch x 4 inch thin gauze dressing was on the bottom of the foot; it was soiled with reddish/brownish discharge and only connected by the lower left corner of the dressing. When Resident 262 moves the foot, the dressing flops around not covering the wound. Resident 262 observed moving the foot on the floor, bed, and on lower metal areas of the overhead bed table. During a concurrent observation and interview on 03/11/20, at 12:41 p.m., with the director of nursing(DON), Resident 262's thin gauze dressing on the bottom of the foot was soiled and only connected by the lower left corner of the dressing. Resident 262 observed moving the foot on the floor, bed, and on lower metal areas of the overhead bed table. The DON confirms the gauze dressing was hanging by a thread, was not covering the wound at all and was an infection control issue for Resident 262 and other residents.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** Based on observation, interview and record review, the facility failed to maintain a call light in working order for Resident 14. This facility failure resulted in Resident 14 being unable to call for help if needed. Findings: During a review of the facility's policy and procedure titled, Answering the Call Light, dated 10/2010, the policy indicates in part, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .be sure that the call light is plugged in at all times .report all defective call lights to the nurse supervisor promptly. During an observation and concurrent interview on [DATE] at 8:56 a.m., with Resident 14 and CNA5 at the bedside of Resident 14, it was noted that the call light for Resident 14 was sitting on the top of the dresser beside the bed, out of reach of Resident 14. When asked what she would do if help was needed quickly, Resident 14 began to cry, and stated, I don't know. Asked CNA5 to show me the resident's call light. CNA5 found it on top of the dresser, and stated, It's broken. It's a big problem. CNA5 acknowledged that Resident 14 would not be able to call for help if needed.