STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056378	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENCY OAKS POST ACUTE CARE CENTER	**3850 E. ESTHER ST. LONG BEACH, CA 90804**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview, and record review the facility failed to maintain the respect for one of 18 residents (62), staff were having personal conversation while providing personal care to the resident. This deficient practice could potentially place Resident 62 at not feeling respected during the care. Findings: During an observation on 03/11/20 at 6:30 am, two Certified Nursing Attendants (CNA 20 and CNA 22), who were providing care to Resident 62, were overheard having a personal conversation amongst themselves. The conversation could be heard outside Resident 62's room in hallway. During an interview on 03/12/20 at 12:56 pm, regarding having personal conversation while providing personal care to Resident 62, CNA 20 stated the personal conversation should had never happened. CNA 20 stated she should have taken CNA 22 out of Resident 62's room to have that personal conversation. A review of the facility's revised policy and procedure dated (NAME)2009, titled Dignity, indicated residents shall be treated with dignity and respect at all times. The policy indicated verbal staff to staff communication shall be conducted outside the hearing range of the residents and the public.
F 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to ensure staff was not standing over one of 6 residents (25), when assisting the resident with their meal. This deficient practice might result in Resident 25's dignity and respect not be honored and the resident feeling rushed, while being assisted with their meal. Findings: During an observation on [DATE] at 12:41 p.m., Resident 25 was in bed, who was being assisted by a certified nursing assistant (CNA 11) with the meal. CNA 11 was observed standing by the beside, hovering over Resident 25, while feeding the resident. A review of Resident 25's face sheet, dated 3/12/20, indicated the resident was originally admitted to the facility on [DATE]. Resident 25's [DIAGNOSES REDACTED]. A review of Resident 25's history and physical examination [REDACTED]. A Minimum Data Set (MDS), a standardized resident assessment and care screening tool dated 12/30/19 indicated Resident 25's cognitive skills for daily decision making were moderately impaired. Resident 25 required extensive assistance from staff for eating. During an interview on 3/12/20 at 9:23 a.m., when asked how the staff were to assist the residents who needed assistance with feeding, the director of staff development (DSD) stated, when a staff feeds the resident, the staff had to be in a sitting position. DSD stated sitting while feeding the resident was because it was about preserving their dignity. A review of the facility's policy titled Assistance with Meals revised July 2017, revealed the following: Residents who can not feed themselves will be fed with attention to safety, comfort and dignity, for example: (1) Not standing over residents while assisting them with meals.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to answer call lights in a timely manner, and ensure the call light was within easy reach for 3 out of 6 residents attending group meeting and two of 18 resident (19, 228). This deficient practice caused the three residents who attended the group meeting, Resident 19, and 228 feeling sad, upset, and potentially delayed their care. Findings: a. During a group meeting on 03/10/20 at 1:30 pm, three of 6 alert and oriented residents in attendance, stated their call lights were not answered in a timely manner. The residents stated they had been waiting over 30 minutes for help from the staff members. The residents stated having to wait for the staff to assist them with their activities of daily living made them upset and sad at sometimes. The residents stated waiting for the staff to assist them caused them to have incontinent (involuntary loss of bowel or bladder functions) episides because there was no assistance provided by the staff. A review of the resident council meeting minutes dated 01/27/20, indicated the residents who attended the meeting voiced their concerns about 11-7 pm shift, which were not answering their call lights in a timely fashion. b. According to admission records Resident 228 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), a standardize assessment and care screening tool, dated 03/02/20 indicated Resident 228 had no impairment with cognitive skills for daily decision making, the resident required extensive assistance for activity of daily leaving. During an interview on 03/10/20 at 2:15 pm, Resident 228 stated he waited over an hour and 10 minutes after pushing the call light for staff to assist with activities of daily living. c. On 03/09/20 at 10:29 a.m., during the initial tour of the facility, Resident 19 was observed sitting on his wheelchair next to his bed with bilateral (both) below the knees amputation (removal of a limb). During the observation Resident 19's call light was observed on the floor at the head of the resident's bed. According to the resident, staff did not answerer the call light in a timely manner, especially the night shift. Resident 19 stated whenever the call light was activated, either to use bathroom or obtain items from closet, it took about 30 minutes to 40 minutes for the staff to actually respond to the call light. Resident 19 stated after putting on the call light for more than 35 minutes, when not being assisted, he fell from the wheelchair trying to get an item from his closet. Resident 19 stated he had fallen three times and had pain on his buttocks (behind). A review of Resident 19's Face Sheet indicated the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 19's Minimum Data Set (MDS), a standardized resident assessment and care screening tool dated 12/16/2019, indicated the resident cognitive skills for daily decision making was intact. The MDS indicated the resident required extensive assistant with activities of daily living (ADLs) with one staff assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. A review of Resident 19's ADLs care plan dated 9/14/2018, indicated the presence of contractures of the right hand and bilateral above the knees amputations, and the goal indicated the resident will participate in grooming/hygiene daily. The interventions included, the resident will be assisted with ADLs. d. A review of the facility's resident council meeting minutes dated 2/21/2020 at 11:30 a.m., indicated three of 6 residents who attended the meeting had concerns regarding 11-7 shift staff not being able to assist or answer their call lights in a timely manner. On 03/11/20 at 10:40 a.m., during an interview with the director of staff development (DSD) stated the facility did not have enough staff and acknowledged knowing the residents had reported the call lights took longer than responded time. According to the DSD, the facility had been working to hiring more staff and promised to resolve the call light issues in the future. According to an undated facility's policy and procedures titled Answering the Call Light indicated staff shall respond to the resident's request and needs in a timely manner. According to

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the policy, residents in bed or confined to a chair, staff shall insure the call light is within easy reach of the resident and answerer the call light in a timely manner /as soon as possible.
F 0569 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.** Based on interview, and record review, the facility failed to ensure one of 1 residents (25) do not reach Supplemental Security Income ((SSI) federal welfare program that provides cash assistance to individuals who are either aged 65 or older, blind, or disabled) resource limit (to get SSI the countable resources must not be worth more than $2,000 for an individual) for one person, and if reached, they were promptly notified. This deficient practice had the potential for Resident 25 to lose eligibility for Medicaid (a federal and state program that helps with medical costs for some people with limited income and resources, covering that may include nursing home care and personal care services) or SSI coverage. Findings: A record review of resident trust account balance on 3/12/20 indicated Resident 25's personal accounts had reached SSI resource limit over the $2,000 for an individual to have. During an interview with Social Service Director (SSD) on 3/12/20 at 9:30 a.m., acknolwedged she was informed by the business office about Resident 25's account which had reached SSI's resource limit for one person, but it had never been addressed.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure four of 18 residents (14, 23, 46, 73) had specific choices and treatments communicated through a Physician order [REDACTED]. party was given written instructions for an option to formulate an advance directives, which was kept in the active clinical records. This deficient practice had the potential for Resident 14, 23, 46, and 73 not be given the right to accept or refuse specific medical treatments and have those options honored. Findings: a. A reviewed of the admission records on 3/10/20 at 9:47 a.m., indicated Resident 14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, on 3/10/20 at 9:50 a.m., dated 9/2/19 indicated Resident 14 rarely or never made self-understood and rarely or never understood others. The resident required total assistance from staff with all his activities of daily living. During record review on 3/10/20 at 9:50 a.m., the POLST form for Resident 14 was missing the physician's phone number. b. A review of Resident 23's readmission records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment care screening tool, dated 12/25/19 indicated Resident 23 rarely made self-understood and rarely understood others. The resident required total assistance from staff with all her activities of daily living. During record review on 3/10/20 at 9:50 a.m., there was no indication an advance directive was offered to the resident's responsible party and POLST form were missing the following items: 1. Physician phone number. 2. Physician license number. 3. Physician name printed. c. A review of Resident 46's admission record indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS, a resident assessment care tool), dated 1/24/20, on 3/10/20 at 9:50 a.m., indicated Resident 46 rarely made self-understood and rarely understood others. The resident required total assistance from staff with all her activities of daily living. During record review on 3/10/20 at 9:50 a.m., the POLST form were missing the following: 1. Physician phone number. 2. Physician license number. 3. Physician name printed. 4. Date. 5. Physician signature. d. A review of Resident 73's readmission records on 9:47 a.m., indicated she was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment care screening tool, dated 2/11/20, indicated Resident 73 usually made self-understood and understood others. The resident required total assistance from staff with all her activities of daily living. During record review on 3/10/20 at 9:50 a.m., the POLST form were missing the following: 1. Physician phone number. 2. Physician license number. During an interview with the Social Service Director (SSD) on 3/10/20 at 9:47 a.m., acknowledged Resident 23 had no advance directives placed in the active clinical records and was unable to indicate if it was offered to the resident's responsible party. SSD stated Resident 14, 23, 46, and 73, all had incomplete POLST forms.
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 a homelike environment, exceeding comfortable sound levels when the linen barrels made loud noise, staff talking in loud voice, knocking loudly on the doors, for six of 6 residents, who attended the group meeting. This deficient practice affected the residents sleep pattern. Findings: During a group meeting on 03/10/20 at 1:30 pm, six of 6 residents, in attendance who were alert and oriented, complained about the linen barrels making a loud noise. The residents stated the staff rolled their linen barrels into their doors making loud, banging noise. The residents stated staff were loud in the hallways when conversing with other staff members. The residents stated the staff were not mindful in using low voice when speaking to their roommates while they were sleeping. The residents stated staff also knocked really loud on their doors which woke them up out of their sleep. On 03/12/20 at 7:00 am, during observation the linen barrels were loud. While interviewing the Administrator, the conversation could not be heard because of the loudness of the linen barrels. The Administrator stated she was having maintenance staff fix the wheels on the barrels. A review of the facility's revised policy titled Noise Control dated (NAME)2014, indicated personnel should refrain from making loud noises or talking in loud voice when communicating with co-workers and during shift change. The policy indicated excessive noise from equipment should be reported to the maintenance department (squeaky medication/food carts, cleaning equipment, laundry hampers).
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman (patient advocate), when one of 3 closed records (32) residents was transferred from the facility to the general acute care hospital (GACH). This deficient practice had the potential for Resident 32 not having the added protection from the Office of the State Long-Term Care Ombudsman. Findings: A review of Resident 32's admission records indicated she was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of physician order [REDACTED]. During an interview on 3/12/20 at 3:25 p.m., regarding sending a copy of the notice of transfer to a representative of the Office of the State Long-Term Care Ombudsman with Social Service Director stated and acknowledged there was no notification given to the Ombudsman office for Resident 32, who was transferred out to the GACH.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure Minimum Data Set ((MDS) a standardize assessment and care screening tool that yields information about a resident's functional status, strengths, weaknesses, and preferences, and it offers guidance on further assessment once the problems are identified) assessment was submitted timely to the Assessment Submission and Processing (part of quality improvement and evaluation system where the required assessment is

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) submitted and processed) database system for six of 6 residents (1, 2, 3, 4,13, 44). This deficient practice had the potential to provide inadequate assistance level to Resident 1, 2, 3, 4, 13, 44, and information to the MDS database system when the MDS assessment was not submitted in a timely manner. Findings: a. A review of Resident 1's admission records on 3/12/20 at 11:00 a.m., indicated he was readmitted to the facility on with [DIAGNOSES REDACTED]. b. A review of Resident 2's admission records on 3/12/20 at 11:00 a.m., indicated she was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. c. A review of Resident 3's admission records on 3/12/20 at 11:00 am., indicated she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. d. A review of Resident 4's admission records on 3/12/20 at 11:00 a.m., indicated he was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. e. A review of Resident 13's admission records on 3/12/20 at 11:00 a.m., indicated she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. f. A review of Resident 44's admission records on 3/12/20 at 11:00 a.m., indicated she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During interview on 3/12/20 at 2 p.m., with the MDS nurse acknowledged Resident 1, 2, 3, 4,13, and 44's MDS assessment was not submitted in a timely manner, causing it to go over 120 days. A review of the facility's revised policy and procedure dated 7/17 titled MDS Completion and Submission Timeframes Indicated the following: 1. Our facility will conduct and submit resident assessments in accordance with current federal and state submission and timeframes. 2. The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' OIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 3. Timeframes for completion ad submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. 4. Submission of (MDS) records to the QIES ASAP is electronic.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess two of 19 residents Minimum Data Set ((MDS) a standardized assessment and care screening tool) assessment by: Resident 19, who receiving [MEDICAL TREATMENT] ((H/D) a clinical treatment for [REDACTED]. Resident 178, the 14 th day MDS assessment was not completed when the resident was placed on hospice care (a special kind of care provided to resident who are experiencing an advanced, life disease). These deficient practices had the potential for Resident 19, and 178 not to receive the appropriate care due to an inaccurate MDS assessments. Findings: a. On 0[DATE] at 03:51 p.m., observed Resident 19's left hand Quinton catheter for H/D access site that was covered with a clean and dry dressing. A review of Resident 19's Face Sheet indicated the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 19's MDS assessment dated [DATE], indicated the resident cognitive skills for daily decision making was impaired. The MDS also indicated the resident required extensive assistant with activities of daily living (such as bed mobility, transfer, dressing, toilet use, personal hygiene exception of eating) with the assistance of one staff person. However, Resident 19's MDS assessment section O was not triggered for [MEDICAL TREATMENT] services. A review of the physician order [REDACTED]. assessment section O not triggered for [MEDICAL TREATMENT]. During a concurrent interview with the MDS nurse acknowledged section O was missed. MDS nurse stated amended section O for the MDS dated [DATE] would be computed and resubmitted. According to MDS nurse not accurately coding the MDS assessment had the potential for staff not providing resident-centered care. b. A review of Resident 178's Face Sheet, indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the history and physical assessment form dated 2/10/20 indicated Resident 178 had [DIAGNOSES REDACTED]. A review of the physician order [REDACTED]. According to the MDS nurse he had not been able to get to the MDS assessment but he followed an MDS calendar. MDS nurse stated Resident 178 was placed on hospice care on the same day he was admitted to the facility. According to the MDS nurse, the MDS assessment was initiated on 2/9/20 but not completed within the 14 days. The MDS nurse stated the rational for the MDS assessment was to get all the information to develop a resident's specific plan of care. According to the MDS nurse, the delay in the MDS assessment caused Resident 178's plan of care to be delayed which could affect the quality of care provided to the resident.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to incorporate the recommendations of for one of 19 residents (28) Preadmission Screening and Resident Review ((PASARR) a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) level II evaluation into the resident's care plan. The deficient practice could potentially result in the specific assessed PASARR level II not be provided to Resident 28. Findings: A review of Resident 28's face sheet (admission record) indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 28's [DIAGNOSES REDACTED]. A review of a letter from the California Department of Health Care Services dated 11/21/2019, indicated Resident 28's PASARR level II evaluation was completed on 10/4/19 with care recommendations to ensure the resident received the adequate services in the facility. On 3/12/20 at 1:23 p.m., during a concurrent record review and interview with director of nursing (DON) confirmed the State recommended services for PASARR level II was not integrated into Resident 28's care plan. A review of the Minimum Data Set (MDS), a standardized resident care assessment and screening tool dated 1/1/20 indicated Resident 28's cognitive skills for daily decision making was intact. Resident 28 required extensive assistance for bed mobility, personal hygiene care, dressing, and was totally dependent on staff for toilet use.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement comprehensive plans of care for two of 18 residents (23, 46) by: Resident 23, who was on a ventilator (machine designed to move breathable air into and out of the lungs, to provide breathing for a patient who is physically unable to breathe, or breathing insufficiently) did not indicate an emergency intervention of providing an [MEDICAL CONDITION] set (provides an air passage to help you breathe when the usual route for breathing is obstructed or impaired) inner cannula (inner cannula fits inside the outer cannula (outer tube that holds the [MEDICAL CONDITION]) for emergency if it was dislodged. Resident 46, who was on a ventilator of how the emergency interventions for care plan problem how the ventilator was to be plugged in a designated emergency wall outlet, and providing an [MEDICAL CONDITION] set of the same or smaller size available in the designated area in the resident room in case of accidental/self-decannulation. According to Residents Census and Conditions of Residents there were 20 residents receiving respiratory and 14 receiving [MEDICAL CONDITION] care. These deficient practices placed Resident 23, and 46 at risk when there was an emergency situation and potentially necessary care and services not being provided. Findings: a. A review of Resident 23's readmission records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 12/25/19 indicated Resident 23 rarely made self-understood and rarely understands others. The MDS assessment indicated Resident 23 required total assistance from staff with all her activities of daily living. A record review of Resident 23's care plan dated 1/09/18 did not indicate the following emergency interventions for the problems of providing an [MEDICAL CONDITION] set of the same or smaller size available in the designated area in the resident room in case of accidental/self-decannulation. b. A review of Resident 46's admission records indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a standardized resident assessment and care screening tool dated 1/24/20 indicated Resident 46 rarely made self-understood and rarely understands others. The resident required total assistance from staff with all her activities of daily living. A record review of Resident 46's care plan dated 3/5/20 indicated there was no emergency interventions for care plan problem for how the ventilator was to be plugged in a designated emergency wall outlet, and providing an [MEDICAL CONDITION] set of the same or smaller size available in the designated area in the resident room in case of accidental/self-decannulation. During an interview with the Registered Nurse 2 on 3/12/20 at 12:21 p.m., acknowledged there was no care plans for how the ventilator was to be plugged in a designated emergency wall outlet, and providing an [MEDICAL CONDITION] set of the same or smaller size available in the designated area in the resident room in case of accidental/self-decannulation.

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3)
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, record review, interview, the facility failed to ensure the care plan for four of 19 residents (28, 53, 65, 228) were established to reflect their individualized care needs. These deficient practices may have potential resulting in individualized care not being delivered or monitored for Resident 28, 53, 65, and 228. Findings: a. During observation and interview on [DATE] at 10:16 a.m., Resident 65 was receiving oxygen (O2) via nasal cannula (a small, flexible tube that contains two open prongs intended to sit just inside a person's nostrils for O2 use). Resident 65 was receiving 4 liters per minute (L/min) of O2 flow and stated was having difficulty breathing. During observation one of the nasal cannula prongs was off from Resident 65's nostril. On [DATE] at 11:17 a.m., licensed vocational nurse (LVN 11) checked on Resident 52's O2 tube. LVN 11 checked the resident's nasal cannula, stating this is definitely an issue, then adjusted the tube to ensure the prongs of cannula were in Resident 52's nostrils. A review of Resident 65's face sheet (admission record) indicated the resident was admitted to the facility on [DATE]. Resident 65's [DIAGNOSES REDACTED]. A review of Resident 65's care plan indicated no care was established for the usage of Oxygen and how the Oxygen was to be monitored. On 3/12/20 at 7:50 a.m., during a concurrent record review and interview, the assistant director of nursing (ADON) verbally confirmed there was no care plan to address the Oxygen use including to monitor effectiveness and side effects of the therapy. A review of the Minimum Data Set (MDS), a standardized resident assessment and care screening tool dated 12/31/19 indicated Resident 65's cognitive skills for daily decision making was moderately impaired. Resident 65 required extensive physical assistance for bed mobility, dressing and personal hygiene care. The resident was totally dependent on staff for eating and toileting. According to the facility's policy titled Care Plans, Comprehensive Person-Centered, revised December 2016, indicated the following: the comprehensive, person-centered care plan will: incorporate identified problem areas; incorporate risk factors associated with identified problems; reflect treatment goals, timetables and objectives in measurable outcomes. b. A review of Resident 28's face sheet (admission record) indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 28's [DIAGNOSES REDACTED]. A review of physician order [REDACTED]. of [MEDICATION NAME] including monitoring of effectiveness and side effects while receiving the medication. On 3/12/20 at 7:50 a.m., during a concurrent record review and interview, the assistant director of nursing (ADON) confirmed there was no care plan established for Resident 28's [MEDICATION NAME] use. A Minimum Data Set (MDS), a standardized resident care assessment and screening tool, dated 1/1/20 indicated Resident 28's cognitive skills for daily decision making was intact. Resident 28 required extensive assistance for bed mobility, personal hygiene care, dressing, and was totally dependent on staff for toileting. The facility's titled Care Plans, Comprehensive Person-Centered, revised December 2016, indicated the following: the comprehensive, person-centered care plan will: incorporate identified problem areas; incorporate risk factors associated with identified problems; reflect treatment goals, timetables and objectives in measurable outcomes. c. During a concurrent observation and interview on [DATE] at 9:58 a.m., Resident 53 verbalized he was not able to see, stating he was blind. A review of Resident 53's face sheet (admission record) indicated the resident was admitted to the facility on [DATE]. Resident 53's [DIAGNOSES REDACTED]. A review of Resident 53's Minimum Data Set (MDS), a standardized resident assessment and care screening tool dated 11/15/19, indicated the resident's ability to see in adequate light was severely impaired. The MDS assessment indicated Resident 53 had no vision or could see only light, colors or shapes; and the eyes did not appear to follow objects. The same MDS assessment also indicated Resident 53's cognitive skills for daily decision making were moderately impaired. The resident required extensive assistance for bed mobility, dressing, eating and personal hygiene. Resident 53 was totally dependent on staff for toileting. However, A review of Resident 53's care plan indicated no care plan to address the resident's visual impairment related to [MEDICAL CONDITION]. The facility's titled Care Plans, Comprehensive Person-Centered, revised December 2016, indicated the following: the comprehensive, person-centered care plan will: incorporate identified problem areas; incorporate risk factors associated with identified problems; reflect treatment goals, timetables and objectives in measurable outcomes. d. A review of the admission records for Resident 228 indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), a standardize assessment and care screening tool, dated 03/02/20 indicated Resident 228 was no cognitively impaired with daily decision making and required extensive assistance for activity of daily living. During an interview with Resident 228 on 03/10/20 at 2:15 pm, the resident stated he had not seen a clergy since he was admitted . Resident 228 stated it not matter what religion the clergy was. A review of the activity assessment evaluation indicated Resident 228 stated doing his favorite activity was very important to him. Resident 228 also listed religious service or practices as being important to him. However, the resident's interest was not listed in care plan. A review of Resident 228 care plan dated 02/26/20 for activity did not list any measurable goals, strengths/needs, and personal interest for liking religious services or practices, and seeing a clergy as a part of activity interests. During an interview with activity assistant on 03/12/20 at 8:46 pm, stated she did not offer Resident 228 activity of choice. The activity assistant stated there was a standard calendar created by activity director that tells her what to do for all of the residents. A review of the facility's policy dated 12/2016 titled Care plan, indicated person-centered care plan that includes measurable objectives and timetables to meet physical, psychosocial and functional needs is developed for each resident. The policy indicated care planning include an assessment of resident's strengths and needs; and incorporate the resident's personal and cultural preferences in developing the goals of care. A review of the facility's revised policy dated (NAME)2018 titled Activity Evaluation indicated the activity evaluation is used to develop an individual activities care plan that will allow the resident to participate in activities of his/her choice and interest. The policy indicated that each resident's care plan relates to his/her comprehensive assessment and reflects his/her individual need.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** b. On 3/12/20 at 9:00 a.m., during an emergency crash cart inspection for Sub-Acute unit accompanied by Registered Nurse (RN 2), the document indicated crash cart had been used on 3/11/20 in a code. The checklist indicate that all items should be on the cart and available in case of an emergency. However, a blood pressure cuff was missing from the cart. During an interview with registered nurse (RN 2) acknowledged crash cart checklist indicated blood pressure cuff should be on the crash cart and acknowledged it was not. RN 2 stated the crash cart was used on 3/11/20 when a resident had an emergency situation. Based on observation, interview, and record review, the facility staff failed to meet professional standards of quality for one of 19 residents (35) by: Ensuring the apical pulse (a measure of cardiac function that is completed by placing a stethoscope (medical instrument with a small disk-shaped resonator that is placed against the chest to listening to action of the heart or breathing)) at the apex (the lowest superficial part of the heart) of the heart and counting for one minute, was not monitored at the right anatomical part of the body. Ensuring Resident 35's Vitamin D 250,000 units was available and given as scheduled with the 9 am., medications every Monday. Ensuring Resident 35's information regarding the pacemaker (a small device that is placed in the chest or abdomen to help control abnormal heart rhythms) was available and filed in the clinical records. Ensuring staff was knowledgeable of Resident 35's [DIAGNOSES REDACTED]. Ensuring Resident 35's was scheduled for cardiology appointment for monitoring the pacemaker functions. Ensuring the crash cart was stocked with blood pressure cuff to be used in case of an emergency situations involving the residents. These deficient practices had the potential for Resident 35's pacemaker not functioning properly, not knowing the apical pulse set rate and accurate values, when the staff took radial pulse (heart reate felt in the wrist) instead of apical pulse, and not stocking the crash cart with blood pressure cuff could endanger the residents. Findings: a. On 03/09/20 at 11:02 a.m., during medication pass observation for Resident 35 given by licensed vocational nurse (LVN 1), LVN 1 took Resident 35's apical pulse by placing her three fingers on the resident's left wrist for two minutes. According to LVN 1 Resident 35's radial pulse reading was 64 beats per minute. LVN 1 stated Resident 35 Vitamin D 250,000 unit one capsule will not be given with the rest of the scheduled 9 am medications. According to LVN 1, Vitamin D 250,000 units had to be given once a week on

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Monday at 9 a.m. According to LVN 1, Vitamin D 250,000 units was not available because the medication was not refilled within the five day period in accordance with the facility's policy for refills. According to LVN 1, registered nurse 1 had called the pharmacy for refill the medication on 03/09/20, but said she was not sure of the time. A review of Resident 35's Admission Records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of 35's history and physical (H/P) dated 10/16/2019, indicated the resident had fluctuating capacity to understand and make decisions. H/P also indicated the resident had a cardiac pacemaker. A review of Resident 35's Minimum Data Set (MDS), a standardized assessment and care screening tool) dated [DATE], indicated cognitive skills of daily decision making were intact. The MDS also indicated the resident required extensive assistance with activities of daily living. A review of Resident 35's physician order [REDACTED]. A review of the medication administration records (MARs) dated 3/1/20 -[DATE], indicated Resident 35 was not given Vitamin D 250,000 unit. According to the side note on the MAR, medication was not on hand at this time, and waiting pharmacy to delivery. A review of Resident 35's clinical records had no documented evidence to indicate Resident 35's cardiac pacemaker information such as year of implant, model, serial number and the cardiologist, and the last time the resident visited the cardiologist for check up. A review of the nurse's notes dated [DATE] at 11:43 a.m., 3:15 p.m., indicated still waiting for pharmacy to deliver vitamin D 250,000 unit and, another note at 6:23 p.m., indicated a family member was contacted and requested information regarding cardiologist information and information about the pacemaker. On 03/09/20 at 03:32 p.m., during an interview with LVN 1 who was the charge nurse, did not know Resident 35 had the presence of a cardiac pacemaker. LVN 1 could not verbalized and or show anatomical location of the apical pulse on the resident's body. On 03/09/20 at 12:49 p.m., during an interview with registered nurse (RN 1) stated medication refills should be done within 72 hours. RN 1 confirmed Resident 35's vitamin D 250,000 unit was called for refill at 9 a.m. on [DATE]20. RN 1 stated the medications was a standing order and should have been reordered on [DATE] following the five day, per facility's policy and procedures for refills. According to RN 1 not receiving any medication in a timely manner had the potential of affecting the therapeutic effect and causing more adverse effects. According to the facility's policy and procedures titled Medication Ordering and Receiving from Pharmacy dated 4/2008, indicated medications have to be dispensed from the pharmacy on a timely basis. According to the policy medications shall be refilled five days in advance of need to assure an adequate supply is on hand.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide an activity of interest, that included religious services for one 18 residents (228). This deficient practice had the potential to effect Resident 228 from reaching his highest physical, mental, and psychosocial well-being. Findings: According to admission records Resident 228 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), a standardize assessment and care screening tool dated 03/02/20 indicated Resident 228 cognitive skills for daily decision making had no impairment and required extensive assistance for activity of daily living. During an interview with Resident 228 on 03/10/20 at 2:15 pm, the resident stated he had not seen a clergy since he was admitted . Resident 228 stated it did not matter what religion the clergy was. A review of the activity assessment dated [DATE], indicated Resident 228 listed religious service as very important to resident. During an interview with Activity Director on 03/11/20 at 7:52 a.m., stated if Resident 228 stated religion was very important she would have someone come in to see him. During interview Activity Director stated there were 2 ladies who came to the facility every Tuesday to offer prayer service for the residents. However, the 2 ladies failed to provide prayer service to Resident 228.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to provide one of 18 residents (228) treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices by: Resident 228, who had joint replacement surgery and presence of right artificial hip joint, was ordered to see an orthopedic doctor but was not followed up with. The deficient practices had the potential of not knowing the progress of Resident 228's hip surgery. Findings: According to admission record Resident 228 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), a standardize assessment and care screening tool, dated 03/02/20 indicated Resident 228 cognitive skills for daily decision making had no impairment and required extensive assistance for activity of daily living. During an interview with Resident 228 on 03/10/20 at 2:15 pm, Resident stated I broke my femur bone. Resident 228 stated it seemed with a serious break like this, it would be followed up with the surgeon or orthopedic doctor so that he would be informed if the bone was healing correctly. A review of the physician order [REDACTED]. The order indicated to re-evaluate after 14 days as needed. During an interview with Administrator 03/12/20 at 7:16 am, stated it was brought to her attention that Resident 228 did not have his follow-up visit with orthopedic doctor. The Administrator stated Resident 228 should have been followed up with orthopedic doctor and did not know what happened. The Administrator stated the issue was part of the investigation right know. During an interview with Registered Nurse 1 on 03/12/20 at 8:13 am stated and acknowledged she failed to carry the order through for orthopedic consult for Resident 228. Based on observation interview and record review the facility's staff failed to: 1. Coordinate care /services for Resident 178 who was placed on hospice (care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill or seriously ill patient's pain and symptoms, and attending to their emotional and spiritual needs) care /services due to end stage [MEDICAL CONDITION]. 2. Endure Resident 178's who has multiple wounds were referred to a wound consultant for proper wound treatment. 3. Ensure the facility's staff and hospice agent assisted Resident 178 with activities of daily living. These deficient practices had the potential of resulting to weight loss, quality services and not meeting the highest practicable physical, mental, and psychosocial well-being as well as proper wounds healing, pain, and infection. Findings: A review, of Resident 178's Face Sheet, indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. On 03/09/20, at 01:30 p. m., observed Resident 178 in bed, awake and disoriented, unkempt, long facial hair,, long and dirty finger nails. In a concurrent interview certified nursing assistant CNA 2 who stated the resident's facial hair had not been sheaved because the facial hairs were too hard to cut using a razor, According to CNA 2, the resident's facial hair had to be cut with an electric machine which the facility did not have. CNA 2 further stated the hospice staff had to provide the resident with personal hygiene and the facility's staffs could only help to clean the resident's mouth, wet diaper when the agency staff do not visit. According to CNA 2 resident had multiple pressure ulcers or bed sore as a result of bed confinement. A review of Resident 178's physician's orders [REDACTED]. A review of the admission report and wound managed detail report dated 1/27/20, indicated . 1. Left hip pressure ulcer unstageable length with 7.4 centimeters (cm), width 4 cm, depth 1 cm eschar tissue 75 percent with foul smell odor noted. and continue treatment. However, clinical record indicated stantyl ointment daily after clean with normal saline. 2. right heel trochanter 3. right sacrum with unstageable 3. left trochanter unstageable left lower hip with stage 3 A review of the wound care nurse's note dated 2/27/2020 at 12: 52 p. m., indicated left hip pressure ulcer not healing, had increased in size 6.5 cm x 4 x unstageable (utd), black eschar hard to touch with heavy drainage with light odor. Note indicated the request was made for the hospice agency for a wound consultant. However, the was no follow up documentation enforcing the request. A review of the physician's orders [REDACTED]. However, there was no blood work or wound culture laboratory work order to roll out the specific organism so as to provide appropriate antibiotic. On 3/12/2010, at 11:45 a. m., during an interview with the treatment nurse licensed vocational nurse LVN 2 stated a request was made asking the hospice agency to offer a wound consultant for the resident. According to the LVN 2,the hospice agency turned down the request for the wound consultant. LVN 2 was asked if the director of nursing or medical director was aware, LVN 2 had no comment. On 03/12/20, at 11:17 a. m., during an interview with the hospice case manager, registered nurse RN CM/RN stated director of patient care. According CM/RN the director of patient care said wound consult specialist was not an option or a plan of care for hospice patient. When asked if the hospice's physician was informed, CM/RN stated [MED] and [MEDICATION NAME] was ordered for the wound infection. According to CM/RN no wound culture was ordered. CM / RN stated the facility's staff inform the agency that the resident's wound does not look

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) good and it has a lot of slough, and drainage. According to the CM /RN, CNA from the hospice agency had to visit the resident twice a week for ADLs care and the skilled facility had to provide daily care as well. On 03/12/20, at 11:35 a. m., during an interview with the Director of patient care (DOPC) acknowledged the resident had several wounds. DOPC confirmed a wound consultant had not been order since the facility's staff informed the hospice agency. When questioned DOPC stated wound consultant should have been ordered. According to the DOPC the hospice agency was aware of Resident 178'S wounds had slough and were draining with foul odor. DOPC further stated that was the reason why ordered for Santyl ointment and Antibiotic was given. When asked if wound culture and pain medication prior to wounds care was given DOPC stated no, but treatment were based on symptoms. According to DOPC , the facility failed to implement the hospice agreement for better patient care coordinator. According to the hospice services agreement entered on 1/24/2020 with the skilled nursing facility indicated the facility and the hospice agency would coordinated plan of care that includes directive for managing pain and all other hospices services as per the contractual agreement. The plan of care shall be revised and updated as necessary to reflect the resident's current status. The facility will ensure that the hospice services meet professional standards and principles that apply to individuals providing the services in the facility, and to the timelines of the services and a communication process on how services, change in condition and documentation between facility and hospice agency regards to the resident are addressed and met.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent complications for one of 18 residents (5), from the gastrostomy tube ((GT) small tube placed directly into the stomach through an abdominal wall incision used for the administration of food, fluid and medications) site /skin was assessed every shift, and treated. The deficient practice of not assessing Resident 5's GT site covered by an abdominal binder (a wide compression belt that encircles your abdomen) had potentially resulted in skin irritation and skin breakdown. Findings: On 03/09/20 at 10:30 a.m, during a general tour of the facility, Resident 5 was observed lying in bed, but was non verbal (unable to carry out conversations). The resident had Glucerna 1.5 kilogram of calories (formula) infusing via pump at 65 milliliters (ML) per hours. Certified nursing assistant (CNA 1) and director of staff development (DSD) were observed applying an abdominal binder on the resident's abdomen. In the process of the CNA 1 and DSD applying the binder, Resident 5 was observed with rash, and skin breakdown around the GT site where the abdominal binder had irritated the skin and caused small wounds. During observation on the same day at 10:30 a.m to 11:05 a.m., Resident 5 was observed rubbing the abdominal area because of the [MEDICATION NAME] from the abdominal binder. During a concurrent interview with CNA 1 stated the abdominal binder had to be applied on Resident 5's abdomen for the entire day to prevent the resident from pulling off his GT. A review of Resident 5's Admission Record (Face Sheet) indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 5's Minimum Data Set (MDS), a standardized assessment and care screening tool dated 2/7/2020, indicated the resident cognitive skills for daily decision making were severely impaired and the resident was totally dependent on two staff members for activities of daily living. A review of Resident 5's physician order [REDACTED]. A review of Resident 5's clinical record had no documented evidence indicated the resident had pulled off his GT or staff had been assessing the GT site for skin break down during every shift. A review of Resident 5's care plan dated 2/3/20, with a goal indicated the GT will remain patent and in place. The intervention was to apply abdominal binder as ordered or indicated. However, the intervention did not address how the skin around the abdominal binder was to be assess every shift and documented. A review of the nurses notes dated [DATE]20 at 10:23 p.m., indicated monitor Resident 5's rash on the left chest wall, left upper / lower abdominal area, right upper abdominal area, redness to the mid-abdominal area, and urethral slit. However, the was no indication as to how the rash and the mid abdominal area had to be treated into the resident's clinical record.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure four of 18 residents (14, 23, 46, 73), who were using ventilators (machine designed to move breathable air into and out of the lungs, to provide breathing for a patient who is physically unable to breathe, or breathing insufficiently) connected to [MEDICAL CONDITION] (provides an air passage to help you breathe when the usual route for breathing is obstructed or impaired) with an inner cannula (inner cannula fits inside the outer cannula (outer tube that holds the [MEDICAL CONDITION]), airway circuit (tubing) be secured and residents with facial hair did not obstruct viewing of artificial airway. According to Residents Census and Conditions of Residents there were 20 residents receiving respiratory and 14 [MEDICAL CONDITION] care. These deficient practices had the potential for Resident 14, 23, 46, 73 [MEDICAL CONDITION] to become accidentally dislodge and residents facial hair obstruct viewing of the artificial airway and hindering further assessment. Findings: During initial tour on [DATE] and during observations on 3/10/20, 3/11/20, and 3/12/20 Resident 14, 23, 46, and 73 airway circuit tubing were unsecured on: 1. Hanging on feeding pumps. 2. Hanging off dressers. 3. Hanging on bedrails. a. A reviewed of the admission records indicated Resident 14's was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool) dated 9/2/19 indicated Resident 14 rarely or never made self-understood and rarely or never understood others. The resident required total assistance from staff with all his activities of daily living. b. A review of Resident 23's readmission records indicated she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment and care screening tool dated 12/25/19 indicated Resident 23 rarely made self-understood and rarely understood others. The resident required total assistance from staff with all her activities of daily living. c. A review of Resident 46's admission records indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment and care screening tool, dated 1/24/20 indicated Resident 46 rarely made self-understood and rarely understood others. The resident required total assistance from staff with all her activities of daily living. d. A review of Resident 73's readmission records indicated she was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment and care screening tool dated 2/11/20 indicated Resident 73 usually made self-understood and understood others. The resident required total assistance from staff with all her activities of daily living. During an observation and interview with the Respiratory Therapist (RT) on 3/12/20 at 8:15 a.m., acknowledged Resident 14, 23, 46 and 73's airway circuit tubings were unsecured causing for [MEDICAL CONDITION] to potentially become dislodge and residents facial hair was obstruct viewing of the artificial airway.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmacy services and ensure a medication was refilled five days in advance of need to assure an adequate supply was on hand for one of 1 resident (35). This deficient practice resulted in Resident 35 missing scheduled dose of vitamin D 250,000 unit (vitamin D deficiency which could lead to painful bone disease in adults). Findings: On 03/09/20 at 11:02 a.m., during medication pass observation for Resident 35 given by licensed vocational nurse (LVN 1). LVN 1 stated the resident vitamin D 250,000 unit one capsule will not be given with the rest of scheduled 9 a.m, medications. According to LVN 1, vitamin D 250,000 units had to be given once a week on Mondays at 9 a.m. LVN 1 stated vitamin D 250,000 units was not available because the medication was not refilled within the five day period in accordance with the facility's policy for refills. LVN 1 stated registered nurse 1 had called the pharmacy for refill the medication on 03/09/20, but said she was not sure of the time. A review of Resident 35's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 35's Minimum Data Set (MDS), a standardized assessment and care screening tool dated [DATE], indicated the cognitive skills for daily decision making were intact. The MDS also indicated the resident required extensive assistance with activities of daily living. A review of Resident 35's physician order [REDACTED]. A review of the medication administration records (MARs) dated 3/1/20 -[DATE], indicated Resident 35 was not given vitamin D 250,000

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) unit. According to the side note on the MAR, the medication was not on hand at this time waiting on pharmacy to deliver. On 03/09/20 at 12:49 p.m., during an interview with registered nurse (RN 1) stated refill should be done within 72 hours. RN 1 confirmed Resident 35's D 250,000 unit was called for refill at 9 am. on [DATE]20. RN 1 stated the medication was a standing order and should have been reordered on [DATE] following the five day per facility's policy and procedures for refills. According to RN 1, not receiving any medication in a timely manner had the potential of affecting the therapeutic effect and causing more adverse effects. According to the facility's policy and procedures titled Medication Ordering and Receiving from Pharmacy dated 4/2008, indicated medications have to be dispensed from the pharmacy on a timely basis. According to the policy medications shall be refilled five days in advance of need to assure an adequate supply is on hand.
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 record review and interview, the facility failed to ensure the duration for [MEDICAL CONDITION] medication (any medication capable of affecting the mind, emotions, and behavior) [MEDICATION NAME] (a prescription medical treatment used to manage anxiety) used as needed for one of 5 residents (65) was limited to 14 days and it could not have been renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication. This deficient practice potentially resulted in Resident 65 receiving an unnecessary medication. Findings: A review of Resident 65's clinic records revealed [MEDICATION NAME] (a prescription medical treatment used to manage anxiety) 0.5 milligrams was initially ordered for the resident on 12/19/19 to give every 6 hours as needed (PRN) for anxiety/agitation. There was no duration in the order for the medication use. The order of [MEDICATION NAME] was discontinued on 2/18/20 and reordered on [DATE], however, the new order did not indicate a duration for the medication use. A review of Resident 65's face sheet (admission record) indicated the resident was admitted to the facility on [DATE]. Resident 65's [DIAGNOSES REDACTED]. A review of Resident 65's history and physical examination [REDACTED]. On 3/12/20 at 7:50 a.m., during a concurrent record review and interview, the assistant director of nursing (ADON) confirmed the initial [MEDICATION NAME] order did not specify for 14 days PRN use, and the renewed order had no indication of duration for the PRN use. A review of the Minimum Data Set (MDS), a resident assessment and care screening tool dated 12/31/19, indicated Resident 65's cognitive skills for daily decision making was moderately impaired. Resident 65 required extensive physical assistance for bed mobility, dressing and personal hygiene care. The resident was totally dependent on staff for eating and toileting. The facility's titled Antipsychotic Medication Use policy, revised December 2016, revealed the following: the needs to continue PRN orders for [MEDICAL CONDITION] medication beyond 14 days requires that the practitioner document the rationale for the extended order. The policy indicated the duration of the PRN order will be indicated in the order.
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 the auxiliary services (Podiatrist and Podiatrist Assistant) involved in direct contact with two of 18 residents (23, 46), and their environments, followed patient contact procedures on hand hygiene (washing hands or using hand sanitizer) based on acceptable national standards. The deficient practices increased the risk of spreading communicable diseases (an infection transmissible by direct contact with an affected individual or the individual's body fluids or by indirect means) from staff to resident or resident to resident, potentially resulting in serious health complications including hospitalization or death to Resident 23, and 46. Findings: a. A review of Resident 23's readmission records indicated she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment and care screening tool, dated 12/25/19, indicated Resident 23 rarely made self-understood and rarely understood others. The resident required total assistance from staff with all her activities of daily living. b. A review of Resident 46's admission records indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a resident assessment and care screening tool, dated 1/24/20 indicated Resident 46 rarely made self-understood and rarely understood others. The resident required total assistance from staff with all her activities of daily living. During observation on [DATE] at 9:10 a.m., the following practice was observed from the auxiliary staff, Podiatrist (P) and Podiatrist Assistant (PA): 1. Walking inside Resident 46's room, without washing their hands or use hand sanitizer only changing gloves then performed services. 2 Left out of Resident 46 room, into Resident 23 room without washing their hands or use hand sanitizer only changing gloves then performed services. During an interview on [DATE] at 9:25 a.m., with P he acknowledged not performing hand hygiene prior to checking Resident 23, and 46. During an interview on [DATE] at 9:25 a.m., with PA acknowledged not performing hand hygiene prior to checking Resident 23, and 46. PA stated she was not trained to wash hands before and after working with patients. During an interview with the Administrator on 3/3/20 at 10:00 a.m. acknowledged hand hygiene should have been performed before checking Resident 23, and 46.