STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05E119	A. BUILDING _____ B. WING _____	**05/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TUSTIN CARE CENTER	**1051 BRYAN AVENUE TUSTIN, CA 92780**

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 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their abuse P&P and failed to ensure the staff identified the abuse incident and immediately reported all suspicions of abuse to the Administrator, state agency, and all other required agencies for two of 16 sampled residents (Residents 1 and 2) as evidenced by: * Resident 1 was upset when Resident 2 was transferred to Resident 1's room. Resident 1 threw Resident 2's personal belongings on the floor. Staff 12 had witnessed Resident 1 screamed and pushed Resident 2 and was reported the incident to the SSD. However, the SSD failed to report the resident to resident abuse incident to the Administrator who was the facility's Abuse Coordinator. * Resident 1 was found with bruises on her left hand and wrist when the DON and SSD assessed Resident 1 on the day after the incident between Residents 1 and 2. Resident 1 alleged the SSD was the person who abused her and caused the injury to her arm. The DON and SSD failed to report the resident's allegation of abuse to the Administrator when Resident 1 had alleged being physical abuse by the SSD. * Resident 1's physician was not informed of the physical altercation incident involving Resident 2 and the SSD, and bruises on Resident 1's left hand. * Resident 2 was not assessed after being yelled at and pushed by Resident 1 and was not monitored for any emotional trauma or change of condition. Resident 2's physician was not informed of the incident. * The facility failed to implement their hiring process P&P for conducting the background checks for the newly hired staff (Staff 1, 3, 5, and 14) and verifying the licenses for three new hired licensed nurses (Staff 1, 3, and 5) prior to allowing these staff member to provide care and/or pass the medications to the residents. In addition, the facility failed to conduct the reference checks for the SSD prior to hiring. These failures placed the residents at risk for further abuse, neglect, or misappropriation of resident property. On 5/1/2020 at 1418 hours, the IJ situation was identified due to the above deficient practices and on 5/12/2020 at 1050 hours, the IJ situation was abated after the facility had implemented their plan of corrective actions. Findings: Review of the facility's P&P titled Reporting Elder and Dependent Adult Abuse Policy and Procedure (undated), showed any instance of physical or verbal abuse involving a resident will be reported to the facility's Administrator (Abuse Coordinator). All staff members are responsible for reporting of any witnessed or alleged abuse. All employees are to report the known or suspected instance of abuse, including physical abuse immediately. The supervising nurse will conduct the following: - A full assessment of the resident, immediately notify the Administrator and DON, notify the resident's legal representative, notify the resident's attending physician, document the incident in the licensed nurse's notes, and place the resident on daily charting for 72 hours. 1. Review of Resident 1's medical record was initiated on 5/1/2020. Resident 1 was readmitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 1 had cognitive impairment but did not have mood and behavior problems. Resident 1 was assessed to need the limited assistance with her ADL's. Review of the Social Service Progress Notes dated 4/30/20 at 1400 hours, showed the SSD received the report from the staff about Resident 1's threatening behavior towards Resident 2 and staff. Review of the Resident 1's IDT Notes (undated) showed the incident involving Resident 1 occurred on 4/30/2020 at 1330 hours. The document showed Resident 1 had the history of refusing to have a roommate, and roommate trouble. On 4/30/30, Resident 1 had a new roommate (Resident 2) and Resident 1 threw Resident 2's blankets and clothing on the floor. Resident 1 tried to grab the bedside lamp and displayed threatening behaviors towards others in the room. The SSD tried to stop Resident 1's aggressive behaviors. Review of the SSD's Interview Record dated 4/30/20 at 1330 hours, showed Resident 1 refused to share her room with Resident 2. Resident 1 had physically threatened Resident 2 and staff in the room. Review of Staff 16's Interview Record dated 4/30/2020, showed Staff 16 was called to Resident 1's room by Staff 12 for assistance when Resident 1 was fighting with Resident 2. Staff 16 witnessed Resident 1 holding the arms of the SSD and Staff 12. Staff 16 moved Resident 2 from Resident 1's room. Review of Staff 12's Interview Record dated 5/1/2020, showed on 4/30/2020 at 1330 hours, Staff 12 heard a noise coming from Resident 1's room. Staff 12 witnessed Resident 1 throw away Resident 2's clothing, bedding, and blanket. Staff 12 reported the incident to the SSD. Staff 12 witnessed Resident 1 grabbed the bedside lamp and made a threatening motion to hit someone with it. On 5/1/2020 at 0815 hours, Resident 1 was observed in the dining area. Resident 1 had bruises on the left hand, left wrist, and left lower arm area. When asked what happened to her left hand, Resident 1 started crying and pointed to her left hand and stated trouble, trouble, pain. On 5/1/2020 at 0820 hours, an interview was conducted with Staff 12. Staff 12 stated they witnessed an incident on 4/30/20 at 1330 hours, when Resident 1 yelled and pushed Resident 2 to get out of her room. Staff 12 stated Resident 2 was recently moved into Resident 1's room and Resident 1 was not happy with having a roommate. Staff 12 stated Resident 1 threw Resident 2's personal belongings on the floor and kept yelling at Resident 2. Staff 12 stated they called the SSD for assistance. Staff 12 stated the SSD separated Residents 1 and 2. Staff 12 stated the SSD was observed holding down Resident 1 by holding Resident 1's left hand and tried to get Resident 1 to lay down on her bed. Staff 12 stated Resident 1 continued fighting and hitting the SSD while the SSD was holding her. On 5/1/2020 at 0920 hours, an interview was conducted with Staff 16. Staff 16 stated Staff 12 asked for assistance in Resident 1's room. Staff 16 stated they heard Residents 1 and 2 fighting. Staff 16 stated Resident 1 threw Resident 2's personal belongings onto the floor and pushed Resident 2 out of the room. Staff 16 stated the SSD was in the room and was holding Resident 1's arm to stop the fight. On 5/1/2020 at 1030 hours, an interview was conducted with the SSD. The SSD stated the incident started when Resident 2 was moved into Resident 1's room. The SSD stated Resident 1 did not want any other resident in her room. The SSD stated she was called to provide assistance by Staff 12 when Resident 1 had yelled and pushed Resident 2. The SSD stated she went inside Resident 1's room and tried to calm her down. The SSD stated Resident 1 was yelling and hitting at her. When asked if this incident was reported to the Administrator, the SSD stated she informed the Administrator that Resident 1 did not want a roommate. When asked if an abuse incident was reported to the Administrator, the SSD stated no. The SSD stated Resident 1 had the history of being physically aggressive due to her medical condition. The SSD stated she did not see the incident as an abusive situation and did not report it as such. The SSD stated the resident to resident abuse altercation did not occur since both Residents 1 and 2 had dementia. On 5/1/2020 at 1037 hours, an interview was conducted with the DON. The DON stated she was not aware of the altercation between Residents 1 and 2. The DON stated she was told that Resident 1 did not want any roommate and Resident 2 was moved to a different room. The DON verified there was no abuse reported nor an investigation initiated for the incident between Residents 1 and 2. On 5/1/2020 at 1339 hours, an interview was conducted with the Administrator. The Administrator stated he was not made aware of any altercation incident between Residents 1 and 2. The Administrator stated the SSD reported that Resident 1 did not want a roommate and Resident 2 was moved to another room. The Administrator verified the SSD had not reported any altercation or abuse between Residents 1 and 2. The Administrator stated any incident of the resident to resident altercation was to be immediately reported and investigated. The Administrator was made aware of the altercation between Residents 1 and 2 and he stated the incident happened the day before which was over 24 hours earlier. The Administrator verified the investigation had not been initiated. 2. On 5/1/2020 at 1037 hours, an interview and concurrent observation of Resident 1 was conducted with the DON and SSD. Resident 1 was sitting on her bed and started to cry. Resident 1 pointed to her left hand and stated trouble,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) trouble, pain. The DON assessed Resident 1's left arm and verified bruising to the resident's left hand, wrist and lower arm. Resident 1 complained of pain when the DON assessed Resident 1's left shoulder. The DON stated she would ask the nurse to administer the pain medication to Resident 1. The DON left the room and returned with the SSD. Resident 1 became upset when she saw the SSD. Resident 1 started yelling in an angry tone and pointing at the SSD whiling shouting you, you, trouble, trouble. The SSD stated Resident 1 had accused her of the cause of her pain and bruising to her left hand and arm. The DON talked to Resident 1 and calmed her down. The SSD stated it was Resident 1 who hit her and she needed to protect herself. The SSD stated Resident 1 grabbed the bedside lamp and threatened her and other staff the day before. On 5/1/2020 at 1335 hours (3 hours after Resident 1 was assessed by the DON), an interview was conducted with the DON. When asked where the SSD was, the DON stated the SSD went home because she was not feeling well. When asked if the Administrator was aware of Resident 1's allegation of abuse against the SSD, the DON stated no. The DON verified she did not report the resident's allegation to the Administrator. The DON acknowledged she should have reported it immediately. The DON verified an investigation had not been initiated to address Resident 1's abuse allegation against the SSD or the resident to resident altercation between Residents 1 and 2. On 5/1/2020 at 1339 hours, an interview was conducted with the Administrator. When asked if he was told about Resident 1's allegation of abuse against the SSD, the Administrator stated nothing had been reported to him. The Administrator stated neither the SSD nor DON reported anything to him. The Administrator stated the SSD left the facility without informing him of Resident 1's allegation against her. When asked what happened when the staff was the alleged abuser, the Administrator stated the staff member was to be suspended. When asked if the SSD had been suspended, the Administrator stated no. The Administrator stated the incident had to be reported immediately. The Administrator acknowledged the staff did not report the incident and had not initiated any investigation on Resident 1's abuse allegation. 3. Further review of Resident 1's medical record did not show any documentation related to Resident 1's visible bruises on the left hand. There was no documentation showing Resident 1 was involved in the altercation with Resident 2 and was held down by the SSD as per the facility's P&P. Review of the plan of care failed to identify Resident 1's aggressive behaviors. There was no documented evidence the resident's physician was informed of the incident and bruises as per the facility's P&P. On 5/1/2020 at 1200 hours, the resident's crying was heard from the hallway. Resident 1 was found sitting alone in her room crying. When asked why she was crying, Resident 1 pointed to her hand and stated trouble, trouble, pain. On 5/1/2020 at 1219 hours (2 hours after the DON assessed Resident 1's left hand), an interview was conducted with Staff 2. Staff 2 stated she was not aware of any altercation incident involving Residents 1 and 2. Staff 2 stated Resident 1 had previous episodes of aggressive behavior. When asked, Staff 2 stated Resident 1's aggressive behavior was not being monitored. Staff 2 stated they had not been informed of any injury or bruising to Resident 1's left hand and no change in condition report was initiated. There was no documentation showing Resident 1's attending physician was informed of the resident to resident altercation and bruising to Resident 1's left hand. 4. Review of Resident 2's medical record was initiated on 5/1/2020. Resident 2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 2 had cognitive impairment and needed limited assistance with her ADL care. Review of Resident 2's medical record did not show any documentation of the altercation between Residents 1 and 2. There was no documentation showing Resident 2 was assessed for any possible injuries, emotional trauma, or change in condition. In addition, there was no documentation showing the attending physician was notified of the altercation. On 5/4/2020 at 0915 hours, a concurrent interview and clinical record review for Resident 2 was conducted with Staff 8. Staff 8 stated she was not aware of any altercation between Residents 1 and 2. Staff 8 verified there was no documentation to show the skin assessment was performed for Resident 2 after the resident to resident altercation, and the attending physician was not informed of the incident. Staff 8 acknowledged the body assessment should have been done to check for any injuries. On 5/4/2020 at 0940 hours, an interview was conducted with the DON. The DON acknowledged Resident 2 was not assessed since the resident to resident altercation happened. The DON acknowledged there was no documentation showing Resident 2 was being monitored for any emotional trauma or change of condition following the altercation with Resident 1. 5a. Review of the facility's P&P titled Hiring Process revised 8/09 showed prior to staff hiring, the facility shall ensure provisions covering employment screenings for potential history of abuse, neglect or mistreatment of [REDACTED]. * On 5/4/2020 at 1230 hours, an interview and concurrent facility document review was conducted with the DON. The DON was asked to show documented evidence of the background checks conducted prior to hiring Staff 1, 3, 5, and 14. The DON was unable to find any documentation showing the background checks were conducted prior to hiring and allowing Staff 1, 3, 5, and 14 to provide the resident care and medication administration as per the facility's P&P. * On 5/4/2020 a 1240 hours, an interview and concurrent facility document review was conducted with the DON. The DON was asked to provide documentation to show the newly hired staff had their licenses verified prior to working in the facility. The DON was unable to find any documented evidence showing the license verifications were conducted prior hiring and allowing Staff 1, 3, and 5 to work as per the facility's P&P. b. On 5/1/20 at 1430 hours, a concurrent interview and facility document review was conducted with Staff 7. Staff 7 verified the reference check was not conducted for the SSD prior to her being hired. Staff 7 stated the SSD was not previously employed and she did not ask for any references. Staff 7 acknowledged the reference check was necessary prior to hiring.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure all allegations or suspicions of abuse were reported in a timely manner to the facility's Administrator, local law enforcement and CDPH, L&C Program for two of sixteen sampled residents (Residents 1 and 2). * The SSD failed to identify and report the abuse incident when Resident 1 yelled and pushed Resident 2. The SOC 341- Report of Suspected Dependent Adult/Elder Abuse form for the altercation incident between Residents 1 and 2 was incomplete, inaccurate, and not reported in a timely manner. In addition, there was no documentation showing the incident was reported to the law enforcement. * The DON and SSD failed to inform the Administrator that Resident 1 had made an accusation of physical abuse against the SSD. Resident 1 had developed bruising and swelling to her left hand and wrist. These failures resulted in the delay in assessment for Resident 1's injuries, providing the potential interventions, and investigation of the alleged abuse. Findings: Review of the facility's P&P titled Reporting Elder and Dependent Adult Abuse Policy and Procedure (undated) showed any instance of physical or verbal abuse involving a resident will be reported. All staff members are responsible for reporting of any witnessed or alleged abuse. All employees are responsible for reporting known or suspected physical abuse immediately. If it resulted in serious bodily injury, report within two hours to the following agencies: Local Long Term Ombudsman Office, local law enforcement agency, CDPH, L&C Program, and the Administrator. 1a. On 5/1/2020 at 0815 hours, Resident 1 was observed in the dining area. Resident 1 had bruises to her left hand, left wrist, and left lower arm. When asked what happened to her left hand, Resident 1 started crying and pointed to her left hand and stated, trouble, trouble, pain. On 5/1/2020 at 1030 hours, an interview was conducted with the SSD. The SSD stated there was an incident between Residents 1 and 2. Resident 1 did not want any other resident in her room. The SSD stated she was called to Resident 1's room by Staff 12 when Resident 1 yelled and pushed Resident 2. When asked if the incident was reported to the Administrator, the SSD stated she reported Resident 1 did not want a roommate. When asked if an abuse incident was reported to the Administrator, the SSD stated no. The SSD stated the resident to resident altercation was not abuse since both Residents 1 and 2 had dementia. On 5/1/2020 at 1339 hours, an interview was conducted with the Administrator. The Administrator stated the SSD reported Resident 1 did not want a roommate and Resident 2 was moved to another room. The Administrator verified the SSD did not report the altercation or abuse between Residents 1 and 2. The Administrator stated the resident to resident altercations was to be reported and investigated. The Administrator stated the incident happened the day before, which was over 24 hours earlier. The Administrator verified the investigation had not been initiated and the incident had not been reported to the state agency, ombudsman, and local enforcement. b. Review of the SOC abuse form dated 5/1/2020, showed Resident 1 was identified as the victim of abuse instead of Resident 2. The section for the suspected abuser was blank. Under the section to identify observations, beliefs, statements, the documentation showed on 4/30/2020 around 1100 hours, Resident 1 agreed to share her room with the new roommate. Around 1330 hours, during the room change, Resident 1 displayed aggressive threatening behaviors toward the SSD and Resident 2. Documentation also showed only

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Resident 1's daughter was informed. Resident 2's family member was not informed. The section for the telephone report to the law enforcement was blank. Review of the Fax transmission record dated 5/1/2020, showed the SOC form was transmitted to the CDPH, L&C Program on 5/1/2020 at 1688 hours, 27 hours after the incident had occurred. On 5/6/2020 at 0930 hours, a concurrent interview and facility document review was conducted with the Administrator. The Administrator acknowledged the information on the SOC form was inaccurate and was transmitted over 24 hours after the abuse incident occurred. When asked if the law enforcement was informed about the abuse incident, the Administrator stated the SSD called the police. When asked for the documentation of this call, the Administrator stated he would look for it. The Administrator acknowledged the SOC form was inaccurate and incomplete. 2. On 5/1/2020 at 1037 hours, a concurrent observation and interview with Resident 1 was conducted with the DON and SSD. Resident 1 was observed sitting on her bed and started to cry. Resident 1 pointed to her left hand and stated, trouble, trouble, pain. The DON assessed Resident 1's left arm and verified bruising to the resident's left hand, wrist, and lower arm. Resident 1 complained of pain when the DON assessed Resident 1's left shoulder. The DON left the room and returned with the SSD. Resident 1 became upset when she saw the SSD. Resident 1 started yelling in an angry tone and pointing at the SSD while shouting you, you, trouble, trouble. The SSD stated Resident 1 had accused her for being the cause of her pain and bruises to her left hand and arm. The DON talked to Resident 1 and calmed her down. The SSD stated it was Resident 1 who hit her and she needed to protect herself. The SSD stated Resident 1 grabbed the bedside lamp and threatened her and other staff on the day before. On 5/1/2020 at 1335 hours, an interview was conducted with the DON (three hours after Resident 1 pointed to the SSD as the alleged abuser). When asked if the Administrator was aware of Resident 1's allegation of abuse against the SSD, the DON stated no. The DON acknowledged she did not report the allegation of abuse to the Administrator and acknowledged she should have. The DON verified the investigation had not yet been initiated to address Resident 1's abuse allegation against the SSD. Review of the SOC 341 form dated 5/1/2020, showed Resident 1 reported to the DON she was hit by the SSD and sustained bruises to her left arm. The incident occurred on 4/30/20 at 1330 hours. On 5/1/2020 at 1339 hours, an interview was conducted with the Administrator. The Administrator stated neither the SSD nor DON had reported Resident 1's abuse allegation against the SSD to him. The Administrator stated the SSD left the facility without informing him of Resident 1's allegation. When asked what happened when the staff was alleged to abuse a resident, the Administrator stated the staff member would be suspended. The Administrator stated any allegation of abuse had to be reported to the local law enforcement, ombudsman, and state agencies. On 5/12/2020 at 0823 hours, an interview was conducted with the SSD. When asked if she reported the incident to the law enforcement, the SSD stated she did not have the chance to report it. On 5/12/2020 at 1254 hours, an interview was conducted with the Administrator. The Administrator acknowledged the abuse incidents involving Resident 1 were not reported in a timely manner. When asked if the incident was reported to the law enforcement, the Administrator stated yes. When asked when the report was made, the Administrator stated the report to the law enforcement agency was made on 5/6/2020 at 1648 hours (six days after the incident occurred). The Administrator acknowledged the report to the enforcement agency was late.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide an ongoing activity program to meet the needs and interests of the residents. This failure has the potential to negatively impact the residents' emotional, social and mental well-being. Findings: Review of the facility's P&P titled Activity Program (undated) showed the activity program will be available on a daily basis. a. On 6/23/2020 at 1418 hours, an observation of the facility's dining room was conducted. One resident was observed sitting in the dining room staring at the television. The television was turned off. There was no observed activity being held and no staff members in the room. However, review of the facility's posted activity schedule for June 2020 showed the bingo game was scheduled to be conducted on 6/23/2020 at 1400 hours. On 6/23/2020 at 1422 hours, an interview was conducted with Staff 3. Staff 3 verified there were no activities conducted in the dining room. b. On 6/24/2020 at 1430 hours, an observation of the dining room was conducted. There were no activities observed in the dining room. However, review of the facility's posted activity schedule for June 2020 showed the loterio (lottery) was scheduled to be conducted on 6/24/2020 at 1400 hours. c. On 6/24/2020 at 1600 hours, an observation of the rooms in Station B was conducted. There were no in-room activities or one-on-one activities provided or offered to the residents. On 6/25/2020 at 1030 hours, an interview was conducted with Resident A. Resident A was asked if she liked the activities offered by the facility. Resident A stated there were no activities provided lately. Resident A was asked if anyone in the facility had offered any in-room activities. Resident A stated they did not. On 6/25/2020 at 1050 hours, an interview was conducted with Staff 8. Staff 8 stated there were no activities provided in the facility for several days. Staff 8 stated the activities were currently being conducted because the surveyors were in the facility. Staff 8 was asked when the activities had stopped being provided. Staff 8 stated she was unable to recall the exact date, but the activities stopped when the Activities Director had stopped working. When asked, Staff 8 stated the residents were not offered the activities in their rooms and no one-on-one activities were being provided. On 6/25/2020 at 1532 hours, a facility document review and concurrent interview was conducted with the Administrator, DON and Activities Aide. The Administrator was asked which staff members worked for the activities department. The Administrator stated the Activities Director, Activities Aide, Staff 13, and 14. When asked when the Activities Aide first started working at the facility, the Activities Aide stated she started .just yesterday. When asked if she worked before 6/24/2020, the Activities Aide stated no. The Activities Aide verified she did not work on 6/8, 6/9, 6/10, 6/11, 6/12, 6/18, and 6/19/2020, as listed on the Activity Staffs Schedule. When asked who conducted the activities during those days, the Administrator, DON and Activities Aide did not respond. On 6/26/2020 at 0815 hours, an interview was conducted with Staff 14. Staff 14 stated she worked part-time in the facility and only worked on the weekends. Staff 14 stated the residents had asked her to work more hours due to the lack of activities during the week. Staff 14 stated the Activities Director had gone on leave and no one had taken over her role. Staff 14 was asked if anyone else had been providing the activities. Staff 14 stated they had hired someone else to work on Mondays and Tuesdays; however, Staff 14 stated she was unsure if the person they had hired came to work. Staff 14 was asked where she documented the activities provided to the residents. Staff 14 stated no documentation of the provided activities. Staff 14 was asked if she provided in-room or one-on-one activities to the residents who did not attend the activities in the dining room. Staff 14 stated no. d. On 6/26/2020 at 1100 hours, an observation was conducted in Station B. There were no in-room activities or one-on-one activities provided or offered to the residents. On 6/26/2020 at 1126 hours, a concurrent interview was conducted with Residents OO and NN. Resident OO stated she was bored. Resident OO was asked if she liked participating in the activities. Resident OO stated she did; however, there had been no activities for a while. When asked, Resident OO stated the activities person had not been coming in. Resident OO was asked if anyone else conducted the activities. Resident OO stated sometimes they had activities .but it's all messed up. Resident OO added they had nothing to do all day. Resident OO stated the facility started to have activities recently; however, they did not follow the schedule. Resident NN stated she would like to go to the activities if the facility provided one. Resident NN added she wished they would do activities the way they did before. e. Review of the June Activity Schedule written in the residents' native language showed the game of bingo was scheduled on 6/26/2020 at 1400 hours. On 6/26/2020 at 1428 hours, an observation was conducted in the dining/activities room. There were no activities observed in the dining/activities room. Resident MM was observed entering the dining room, looked around, and left. There was no staff member in the dining room. On 6/26/2020 at 1435 hours, an observation in the dining/activities room and concurrent interview was conducted with the DON. There were no activities observed in the dining/activities room. The DON was asked where the activities were usually held. The DON stated in the dining/activities room. The DON verified no activities were being held at that moment. On 6/26/2020 at 1446 hours, an interview was conducted with Resident MM. Resident MM stated she was admitted in the facility about two months ago. Resident MM stated after the person who conducted the activities stopped coming, there were no activities in the facility. Resident MM stated surprisingly the facility had activities yesterday. Resident MM added she thought the facility would provide the activities from then on. Resident MM stated she went down to the activities room today at around 1400 hours, but nothing was happening. On 6/30/2020 at 1059 hours, a facility document review and concurrent interview was conducted with the DON. Review of the Daily Activities Attendance showed no activities were documented for all the residents for the month of June 2020. The DON verified the findings and stated the facility should have documented the activities and should have provided daily activities for the residents.
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.**

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Based on observation, interview, medical record review, and facility P&P review, the facility failed to report and monitor the resident's change of condition to the primary physician timely for one of 16 sampled residents (Resident 5). This had the potential for Resident 5 to not receive care and treatment timely. Findings: Review of the facility's P&P titled Change of Condition dated 08/09 showed a change of condition includes a sudden or marked change in a resident's complaint, red areas, or rashes. Documentation of a change in condition shall be performed by the licensed nurse for at least 72 hours, or longer if condition change warrants, documenting vital signs each shift. This will include timely notification of resident's physician and family. On 5/5/2020 at 0940 hours, an observation and concurrent interview was conducted with Resident 5. Resident 5's bed had red splattered stains observed on the pillowcase and top one-third section of the bed sheet. Resident 5 stated she had insect bites all over her body and believed they were from bed bugs. Resident 5 stated the red stains on her pillowcase and sheets were blood from the bed bugs. Resident 5 stated her skin was very itchy and she could not sleep for the last three days. Resident 5 added she notified Staff 8 regarding this on 5/4 and again on 5/5/2020, however, the nurse did not address her concerns. On 5/5/2020 at 1147 hours, an observation of Resident 5's skin and concurrent interview was conducted with the DON. Resident 5's skin was observed with red discoloration to her lower back. Resident 5 described her left upper arms as very itchy. Resident 5 pointed to her mattress and stated, .itchy. The DON verified the finding. On 5/5/2020 at 1215 hours, an interview and concurrent medical record review was conducted with Staff 8. Staff 8 was asked if Resident 5 had recently voiced any concerns about feeling itchy. Staff 8 verified on 5/4 and 5/5/2020, she observed Resident 5 scratching her arms and stated they were very itchy. Staff 8 mimicked the scratching motions made by Resident 5 by scratching both of her arms. Staff 8 was asked if she considered this a change of condition. Staff 8 stated yes, this was considered a change of condition. Staff 8 was asked to describe the process when the resident complained of their skin being itchy. Staff 8 stated she would call the physician, document in the nurses note for all three shifts for three days to monitor the resident, and update the resident's plan of care. When asked why this was not done for Resident 5, Staff 8 stated because the residents at the facility were old and they exaggerated things. Staff 8 added the residents wanted attention so they complained. Staff 8 stated the treatment was not provided to Resident 5 because she was old and had dry skin. Staff 8 verified Resident 5's medical record failed to show the skin assessment was done, the physician was contacted, and the treatment was provided to address Resident 5's skin itching. On 5/5/2020 at 1512 hours, a telephone interview was conducted with the DON. The DON stated the change of condition should have been completed for Resident 5 on the day the resident had first voiced her concerns.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the restorative nursing services for 14 nonsampled residents (Residents G, I, J, O, U, CC, DD, EE, II, JJ, KK, LL, 9, and 15) who had received RNA orders from their physicians. This failure had the potential for decline in the residents' range of motion, mobility, and ability to feed self. Findings: On 6/25/2020, at 1030 hours, an interview was conducted with Staff 11. Staff 11 stated the facility did not have an RNA for the past two weeks, and she had to do the feeding for the residents who needed help. Staff 11 stated it was difficult for her because she had to take care of 33 residents during her shift. 1. Medical record review for Resident G was initiated on 6/25/2020. Resident G was admitted to the facility on [DATE]. Review of Resident G's Physician order [REDACTED]. Review of Resident G's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 2. Medical record review for Resident I was initiated on 6/25/2020. Resident I was admitted to the facility on [DATE]. Review of Resident I's Physician order [REDACTED]. Review of Resident I's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 3. Medical record review for Resident J was initiated on 6/25/2020. Resident J was admitted to the facility on [DATE]. Review of Resident J's Physician order [REDACTED]. Review of Resident J's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. On 6/26/2020 at 0832 hours, Resident J was observed in bed. The walker and wheelchair were observed next to her bed. Resident J was asked if she could walk. Resident J stated she could walk with her walker for a short distance, like going to the bathroom. Resident J was asked if she ever walked with the help of a staff member. Resident J stated she never did and had always walked by herself. 4. Medical record review for Resident O was initiated on 6/25/2020. Resident O was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident O's Physician order [REDACTED]. Review of Resident O's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 5. Medical record review for Resident U was initiated on 6/25/2020. Resident U was admitted to the facility on [DATE]. Review of Resident U's Physician order [REDACTED]. Review of Resident U's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. On 6/26/2020 at 0824 hours, Resident U was observed sitting in a wheelchair in her room, with her walker next to her. Resident U stated she could not walk very well. Resident U was asked if anyone helped her with walking. Resident U stated there was someone who walked with her once a day, but the staff member had stopped working. Resident U stated she did not remember exactly how long she stopped working, but not too long ago. Resident U was asked if anyone else helped her with walking after that, she stated no, and stated she didn't walk anymore after that staff stopped working. 6. Medical record review for Resident CC was initiated on 6/25/2020. Resident CC was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident CC's Physician order [REDACTED]. Review of Resident CC's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 7. Medical record review for Resident DD was initiated on 6/25/2020. Resident DD was admitted to the facility on [DATE]. Review of Resident DD's Physician order [REDACTED]. Review of Resident DD's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. On 6/26/2020 at 1030 hours, an interview was conducted with Resident DD. Resident DD stated she had not been able to move her right arm and leg for [AGE] years. Resident DD was asked if anyone performed exercises on her arms and legs, she stated no one did. 8. Medical record review for Resident EE was initiated on 6/25/2020. Resident EE was admitted to the facility on [DATE]. Review of Resident EE's Physician order [REDACTED]. The order did not specify the type of RNA service to be provided. Review of Resident EE's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 9. Medical record review for Resident II was initiated on 6/25/2020. Resident II was admitted to the facility on [DATE]. Review of Resident II's Physician order [REDACTED]. Review of Resident II's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 10. Medical record review for Resident JJ was initiated on 6/25/2020. Resident JJ was admitted to the facility on [DATE]. Review of Resident JJ's Physician order [REDACTED]. Review of Resident JJ's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 11. Medical record review for Resident KK was initiated on 6/25/2020. Resident KK was admitted to the facility on [DATE]. Review of Resident KK's Physician order [REDACTED]. Review of Resident KK's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. 12. Medical record review for Resident LL was initiated on 6/25/2020. Resident LL was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident LL's Physician order [REDACTED]. Review of Resident LL's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. On 6/26/2020 at 0940 hours, an interview was conducted with Resident LL. Resident LL stated he could walk using a walker. Resident LL was

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	05E119	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TUSTIN CARE CENTER	1051 BRYAN AVENUE TUSTIN, CA 92780

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) asked if someone helped him with walking daily. Resident LL stated there was one before, but not anymore. Resident LL was asked how long he had not received the walking exercises, he stated for about 15 days. 13. Medical record review for Resident 9 was initiated on 6/25/2020. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's Physician order [REDACTED]. Review of Resident 9's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. On 6/26/2020 at 0945 hours, an interview was conducted with Resident 9. Resident 9 was asked if she could walk, she stated she could walk by holding on to her wheelchair. Resident 9 was asked if there was anyone helped her with walking, she stated she never had anyone walked with her. 14. Medical record review for Resident 15 was initiated on 6/25/2020. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Physician order [REDACTED]. Review of Resident 15's Restorative Charting Record for June 2020 showed the RNA services were not provided as ordered on 6/8, 6/9, 6/10, 6/11, 6/12, 6/15, 6/16, 6/17, 6/18, 6/19, 6/22, 6/23, 6/24, and 6/25/2020, for a total of 14 days. On 6/25/2020 at 1630 hours, an interview was conducted with the DON and Administrator regarding the status of the RNA in the facility. The Administrator stated the RNA left two weeks ago. The Administrator was asked who was providing the RNA services for the residents with RNA orders. The Administrator stated the CNAs were doing the RNA exercises. The Administrator was asked if the CNAs had been trained to perform RNA services to the residents, he stated no. On 6/25/2020 at 1700 hours, a follow-up interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The The DON stated the missing initials or signatures in the residents' Restorative Charting Records meant the RNA services were not provided to the residents as ordered. On 6/26/2020 at 0720 hours, an observation in the dining room and concurrent interview was conducted with Staff 11. Staff 11 was observed serving breakfast trays to the residents. Staff 11 was asked if she provided RNA services to any residents, which included feeding program, ambulation, and exercises. Staff 11 stated no. Staff 11 stated she passed the trays to the residents and would not be able to assist the residents with the RNA feeding program because they were busy. On 6/26/2020 at 0800 hours, an interview was conducted with Staff 8. Staff 8 was asked regarding RNA services in the facility, which included feeding program, ambulation, and exercises. Staff 8 stated she only helped with feeding the residents, and had a lot of residents to help with. Staff 8 was asked who was providing RNA services to the residents, she stated nobody was doing it. Was asked if she provided RNA services to any residents, she stated no. On 7/2/2020 at 0945 hours, a telephone interview was conducted with the DON. he DON stated there was still no RNA because no one was applying. The DON was asked what had been done by the facility since the RNA left, she stated the CNAs were in-serviced and told to help the residents with ambulation and range of motion exercises. The DON was asked if the facility notified the physicians regarding the RNA services not being provided as ordered due to no RNA in the facility, she stated no. The DON was asked why the physicians were not notified, she stated she thought the CNAs were doing the exercises. The DON was asked what could potentially happen if the RNA services were not provided as ordered. The DON stated the residents may decline in their activities of daily living.
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, medical record review, and facility P&P review, the facility failed to ensure the licensed nurses had specific competencies and skill sets needed to care for the residents. 1. The facility failed to conduct staff competency assessment on the medication administration to the newly hired licensed nurse (Staff 1) as evidenced by: * Staff 1 had pre-poured the medications which were scheduled to be administered at 0730 and 0900 hours. Staff 1 left multiple medication cups filled with various tablets and capsules unattended on top of the unlocked medication cart. * Staff 1 failed to identify the difference between the multivitamin (supplement) and multivitamin with minerals (supplement) medications. Staff 1 administered the multivitamin with minerals tablets to multiple residents instead of the multivitamin tablet as ordered by the physician. * Staff 1 failed to perform hand hygiene and wore the same pair of gloves when administering the medications to multiple residents. * Staff 1 used the residents' meal tickets in the dining room to identify the residents during the medication administration. Staff 1 did not check the resident's identification band. In addition, Staff 1 walked away from the residents without verifying each resident had taken their medications. 2. The facility was unable to provide the employee files for two licensed nurses and one CNA who provided care to the residents. These failures placed the residents at risk for unsafe administration of medications, adverse outcomes, unsafe infection control practices, and medication errors. Findings: Review of the facility's P&P titled Medication Administration-General Guidelines (undated) showed the medications are administered as prescribed in accordance to good nursing principles and practices. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications. The section for Procedure - Preparation, showed the following: - Prior to administration of a medication, each medication and dosage on each resident's MAR (Medication Administration Record) is compared with the medication label. If the label and the MAR indicated [REDACTED]. - Medications are administered in accordance with written physician's orders [REDACTED]. Medications are not pre-poured. - Residents are identified before the medication is administered. Methods of identification include: checking the resident's identification band, checking photograph, calling the resident by name, if necessary verifying the resident's identification with other facility personnel. - Hand washing prior to administering medications. - Medications are administered within sixty minutes of the scheduled time. - During administration of medications, the medication cart is kept closed and locked when out of sight of the licensed medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the licensed nurse administering the medications and inaccessible to residents or others passing by the medication cart. 1. During multiple observations on 5/1 and 5/2/2020, Staff 1 failed to administer the medications to the residents as per the facility's P&P. The following was identified: a. On 5/1/2020 at 0811 hours, Staff 1 was observed leaving Medication Cart 1 unlocked and unattended in the hallway. Multiple medication cups filled with various tablets and capsules were left unattended and unsupervised by a licensed nurse on top of the unlocked medication cart. Several residents were observed passing by this unlocked medication cart. On 5/1/2020 at 0856 hours, an interview was conducted with Staff 1. Staff 1 acknowledged the medications and unlocked medication cart were left unattended. Staff 1 stated she had pre-poured the residents' medications scheduled to be administered at 0730 and 0900 hours. Staff 1 verified the residents' medications scheduled to be administered at 0730 hours were not administered timely. Staff 1 stated she had started working on the day shift (0700 to 1500 hours) at the facility six days ago. When asked if she received or completed her orientation, Staff 1 did not respond. b. On 5/1/2020 at 1110 hours, an inspection of Medication Cart 1 was conducted with Staff 1. Staff 1 was asked if there were residents who had the multivitamin tablet orders. Staff 1 stated yes. When asked what medication she administered to the residents who had the multivitamin tablet orders, Staff 1 showed the bottle of Mature Multi Vitamins and Minerals tablets. Staff 1 stated the Mature Multi Vitamins and Minerals tablets were the same as the multivitamin tablet. c. On 5/1/2020 from 0811 to 0835 hours, Staff 1 was observed passing the medications to the residents from room to room on Station A. The following was observed: - At 0811 hours, Staff 1 was observed entering Room A and wearing a pair of gloves. - At 0814 hours, Staff 1 was observed entering Room B and wearing the same pair of gloves. - At 0825 hours, Staff 1 was observed entering Room C and wearing the same pair of gloves. - At 0835 hours, Staff 1 was observed entering Room D and wearing the same pair of gloves. Staff 1 used the same pair of gloves when she administered the medications to the residents in those rooms. Staff 1 did not perform hand hygiene between each resident. On 5/1/2020 at 0853 hours, an interview was conducted with Staff 1. When asked about hand hygiene between providing care for different residents, Staff 1 stated she had hand sanitizer but forgot to use it. Staff 1 was then observed putting hand sanitizer on her gloved hands and rubbing on the gloves. She did not attempt to remove the gloves to perform hand hygiene and don on a new pair of gloves. On 5/1/2020 at 1110 hours, an interview was conducted with the DON. The DON stated Staff 1 should have performed hand hygiene in between the residents to prevent the spread of infection. On 5/1/2020 at 1227 hours, a follow-up interview was conducted with the DON. The DON was asked if the medication administration competency check was completed with Staff 1. The DON stated the competency check was not done for Staff 1 because the facility did not have enough staff to work on the floor. When asked if the competency check should have been done prior to allowing the staff to work independently on the floor, the DON stated yes, because it was needed for the safety of the residents.

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) d. On 5/2/2020 at 0732 and 0750 hours, Staff 1 was observed passing the medications to the residents in the dining room. Staff 1 was observed holding the tray with multiple medication cups filled with various tablets and capsules, and labeled with different residents' room numbers. Staff 1 was observed approaching one resident and checked the resident's meal ticket. Staff 1 placed the clear medication cup with the resident's room number on the resident's meal tray. However, Staff 1 did not check the resident's arm band to verify the resident's name as per the facility's P&P. Staff 1 turned around and walked away from this resident without checking to ensure the resident had actually taken the medications. Staff 1 did not have the residents' Medication Administration Record [REDACTED]. On 5/2/2020 at 0820 hours, an interview was conducted with Staff 1. Staff 1 stated she prepared the medications for 14 residents ahead of time. Staff 1 stated it was more convenient for her to administer the medications while the residents were in the dining room. Staff 1 stated she checked the residents' meal tickets to identify the residents. Staff 1 acknowledged she did not have any of the residents' Medication Administration Record [REDACTED]. Staff 1 stated she was not familiar with all the residents and only started working in the facility on 4/17/2020, and had worked on floor for six days. 2. On 4/28/2020 at 1430 hours, an interview was conducted with the Administrator. The Administrator was asked if the facility had any temporary staff who worked in the facility. The Administrator stated no, they did not use the staffing registry and did not use the temporary staff; all employees who worked at the facility were the facility's permanent staff. On 4/28/2020 at 1550 hours, a telephone interview was conducted with the DON. The DON was asked who was responsible for assigning the staffing schedule in the facility. The DON stated it used to be Staff 7 and the former DON who were responsible for the staffing schedule, but now, it was Staff A who made the staffing schedule for the facility. The DON was asked if there were employees brought in by Staff A to work in the facility unexpectedly. The DON stated one time, a CNA was brought in to work in early April 2020. On 4/29/2020 at 1053 hours, the DON provided the staffing schedule for the staff who had worked in the facility in April 2020. The DON stated Staff 5 and 17 had worked in the facility for one day in April 2020. Review of the facility's Nursing Staffing Assignment and Sign-in sheet dated 4/15/2020, showed Staff 17 provided care to the residents from 1500-2300 hours. On 5/1/2020 at 1000 hours, an interview was conducted with Staff 7. Staff 7 stated there were employees not scheduled to work that would show up unexpectedly to work in the facility. Staff 7 stated these employees were not brought in through the normal hiring process and she would not know who they were or if they had any employee records. Staff 7 was asked to describe the normal hiring process at the facility. Staff 7 stated before the new owners came, the process was to do the background check, license verification, PPD skin test, abuse training, and other items for orientation. Staff 7 stated that was not done anymore for the new employees or those individuals that came to the facility to work unexpectedly. Staff 7 stated this was brought up to the Administrator and was informed not to worry about it. Staff 7 was asked who did the competency checks for Staff 1. Staff 7 stated the competency checks were normally done by the DON; however, it was not done for Staff 1. Staff 7 was asked to provide the employee files for Staff 1, 5, and 17. Staff 7 stated she did not have their employee files. Staff 7 stated she informed the DON and Administrator of the missing employee files, and they informed her they would contact the new owners to obtain those files. On 5/1/2020 at 1222 hours, an interview was conducted with the DON. The DON was asked to provide the employee files for Staff 1, 5, and 17. The DON stated she could not provide those files. The DON was asked who was responsible in completing the competency checks for the licensed staff. The DON responded she would be the one to do them. The DON was asked if she had completed the competency checks on the licensed staff since she was employed at this facility. The DON stated she had not. When asked why this was not done, the DON stated there was not enough staff. The DON stated the competency checks needed to be completed before the licensed staff provided care for the safety of the residents. On 5/1/2020 at 1441 hours, an interview was conducted with the Administrator. The Administrator stated Staff A was assigned to handle the new employee hiring process, schedule the staff, and obtain the supplies. The Administrator stated Staff A worked for the new owners and was not employed by the facility. The Administrator stated he did not know Staff A's title and job description. The Administrator was asked who made the decision for Staff A to be in charge of the above duties. The Administrator stated the new owners made the changes about a month ago.
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 medical record review, the facility failed to ensure the pharmaceutical services were provided to meet the residents' needs for four of 16 sampled residents (Residents 7, 11, 13, and 15) and 14 nonsampled residents (Residents A, J, L, P, Q, T, V, W, Y, AA, BB, CC, DD, and EE). * The facility failed to ensure sufficient supply of Tylenol (pain medication) 500 mg available in the facility for Residents L, P, and Q who had the order for Tylenol 500 mg to manage their pain. * Staff 3 incorrectly administered Tylenol 650 mg instead of Tylenol 1000 mg to Resident 15 due to the Tylenol 500 mg medication not being available. * The facility failed to ensure the accuracy of the medication administration. Staff 1 pre-poured the residents' medications and failed to verify the residents' identification before administering the medications in the dining room to Residents 7 and 11. * Staff 3 left five residents' medications unattended on top of Medication Cart 1. * Staff 1 failed to administer the multivitamin tablet as ordered by the physician to Residents 13, 15, A, J, Q, T, V, W, Y, AA, BB, CC, DD, and EE. * Staff 1 did not administer the medications scheduled at 0730 hours timely. In addition, Staff 1 failed to ensure the medications and medication cart were secured. These failures could potentially result in the medication administration errors, adverse health outcomes, and not managing the resident's pain appropriately. Findings: Review of the facility's P&P titled Medication Administration - General Guidelines (undated) showed the medications are to be administered in accordance with written orders of the attending physician and to be administered at the time they are prepared. Medications are not to be pre-poured. Residents are identified before medication is administered by checking identification band, checking photograph attached to the medical record, calling resident by name, or verifying resident identification with other facility personnel. The residents is always observed after administration to ensure that the dose was completely ingested. 1. On 4/28/2020 at 1120 hours, an interview and concurrent inspection of Station 2's Medication Cart 2 was conducted with Staff 7. There were no bottles of Tylenol 500 mg tablets observed in the medication cart. Staff 7 verified the finding. Staff 7 stated the supplies had been low for weeks and was concerned the facility did not have enough supplies to meet the needs of the residents. Staff 7 was asked what was done if those medications were not available. Staff 7 did not respond. On 4/28/2020 at 1207 hours, an interview and concurrent inspection of Station 1's Medication Cart 1 was conducted with Staff 3. There were no bottles of Tylenol 500 mg tablets observed in the medication cart. Staff 3 verified the finding. Staff 3 was asked where he could locate the medications if they were not available to him. Staff 3 stated they currently did not have any Tylenol 500 mg tablets available at the facility, but he would normally notify Staff 16. On 4/28/2020 at 1236 hours, an interview and concurrent medication supply room inspection was conducted with Staff 16. There were no bottles of Tylenol 500 mg tablets observed in the medication supply room. Staff 16 verified the finding. On 4/29/2020 at 1355 hours, an interview and concurrent medical record review was conducted with Staff 3. Staff 3 verified he did not have Tylenol 500 mg tablets available yesterday for medication administration. Staff 3 stated for Residents L, P, and Q, he did not administer the routine Tylenol 500 mg tablet as ordered by the physician for pain management. Staff 3 verified he did not notify the physician of the medications not being administered and did not document this information in the residents' medical records. a. Medical record review for Resident L was initiated on 4/29/2020. Resident L was admitted to the facility on [DATE]. Review of the Physician order [REDACTED]. Review of Resident L's Medication Administration Record [REDACTED]. b. Medical record review for Resident P was initiated on 4/29/2020. Resident P was admitted to the facility on [DATE]. Review of the Physician order [REDACTED]. Review of Resident P's Medication Administration Record [REDACTED]. c. Medical record review for Resident Q was initiated on 4/29/2020. Resident Q was admitted to the facility on [DATE]. Review of the Physician order [REDACTED]. Review of Resident Q's Medication Administration Record [REDACTED]. On 4/29/2020 at 1340 hours, an interview and concurrent medical record review was conducted with the DON and Staff 16. The DON was asked to review the pharmacy invoices, Supply Lists, and Supply Received for March and April 2020. Staff 16 stated the pharmacy invoice was not a receipt, but it was a document used to order the supplies. Staff 16 stated the Supply List was another document used by the facility to order the supplies, and the Supply Received was a document she used to keep track of the supplies received by the facility. Staff 16 stated there was no invoice sheet provided to the facility to show when the supplies were delivered. The DON and Staff 16 verified Tylenol 500 mg tablets were ordered on 3/12, 3/17, 3/23, 3/24, 4/1, 4/14, 4/15, 4/23, and 4/28/2020. The DON and Staff 16 verified no bottles of Tylenol 500 mg tablets were delivered from 3/12 to 4/27/2020, despite repeated order requests. The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) DON verified she signed the medication supplies needed on 4/1, 4/15, 4/23, and 4/28/2020. The DON stated this signature meant Staff 16 had shown her which supplies were low or missing. The DON was asked why the supplies ordered were not delivered to the facility. The DON stated she believed the owners of the facility did not want to pay for the supplies. 2. Medical record review for Resident 15 was initiated on 4/29/2020. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Physician order [REDACTED]. Review of Resident 15's Medication Administration Record [REDACTED]. On 4/29/2020 at 1355 hours, an interview and concurrent medical record review was conducted with Staff 3. Staff 3 was asked if he had Tylenol 500 mg tablets available on 4/28/2020, for medication administration. Staff 3 verified he did not. Staff 3 was asked what he did on 4/28/2020, for the residents who had Tylenol 500 mg tablets ordered. Staff 3 stated for Resident 15, he administered Tylenol 650 mg tablet instead of Tylenol 500 mg two tablets as ordered by the physician. Staff 3 verified he did not notify the physician of this and did not document this information in Resident 15's medical record. 3. On 5/2/2020 at 0728 hours, Staff 1 was observed in the dining room holding a silver tray with approximately 10 clear medication cups filled with the pills. Each medication cup was marked with the residents' room numbers. a. Staff 1 was observed walking towards the dining table where Resident 11 was sitting. Staff 1 looked at Resident 11's meal tray ticket. Staff 1 then placed the clear medication cup containing several pills on Resident 11's meal tray. Staff 1 did not check Resident 11's arm band. Staff 1 was observed walking away from Resident 11 before ensuring the medications were taken by the resident. b. On 5/2/2020 at 0732 hours, Staff 1 was observed in the dining room walking towards the dining table where Resident 7 was sitting, and looked at the resident's meal tray ticket. Staff 1 was then observed placing the clear medication cup containing several pills on Resident 7's meal tray. Staff 1 did not check Resident 7's arm band. Resident 7 was observed taking the medications. On 5/2/2020 at 0820 hours, an interview was conducted with Staff 1. Staff 1 was asked to explain how she prepared the residents' medications. Staff 1 stated she prepared the medications ahead of time because it was more convenient for her, otherwise, it would take her a long time to administer the medications. Staff 1 stated she prepared the medications this morning for almost all of the residents in Station 2. Staff 1 added she wrote the name of the residents on the medication cups and handed them to the residents in the dining room. Staff 1 was asked to explain how she knew she was giving the correct medications to the correct resident. Staff 1 stated if the resident had dementia, she checked the armband. Staff 1 stated an old person sometimes knew their name and room number so she would ask. Staff 1 stated she knew this practice was wrong, but she did not know the names of the residents. Staff 1 stated she needed two to three weeks to learn the residents' names. 4. On 5/2/2020 at 0758 hours, Medication Cart 1 was observed unlocked and unattended by the licensed staff in the hallway with five clear medication cups filled with the pills sitting on top of the medication cart. Staff 3 was observed coming out of the resident's room and walking towards the medication cart. Staff 3 verified the medication cups sitting on the medication cart contained the medications for his five residents. Staff 3 stated the pre-poured medications in the medication cups included [MEDICATION NAME] (diuretic medication), [MEDICATION NAME] (antihypertensive medication), Eliquis (anticoagulant to prevent blood clots), [MEDICATION NAME] (antihypertensive medication), multivitamins, and Tylenol. Staff 3 stated each resident's medications should have been administered after preparation. 5. On 5/1/2020 at 1110 hours, an inspection of Medication Cart 1 and concurrent interview was conducted with Staff 1. Staff 1 was asked if she had the residents who had the multivitamin tablet orders. Staff 1 stated yes. Staff 1 verified there was no supply of the multivitamin tablets in the medication cart. Staff 1 was asked what medication she gave to the residents who had the multivitamin tablet orders. Staff 1 showed the bottle of Mature Multi Vitamins and Minerals. Staff 1 stated the Mature Multi Vitamins and Minerals tablets were the same as the multivitamin tablets. On 5/1/2020 at 1150 hours, the list of the residents who had the physician's orders [REDACTED]. Review of Residents A, J, Q, T, V, W, Y, AA, BB, CC, DD, EE, 13, and 15's medical records showed the physician's orders [REDACTED]. On 5/1/2020 at 1440 hours, an interview and concurrent medical record review was conducted with the DON and Staff 1. Staff 1 verified she administered the Mature Multi Vitamins and Minerals to all residents who had the orders for multivitamin tablet. The DON acknowledged the findings and verified the Mature Multi Vitamins and Minerals tablets were not the same as the multivitamin tablets, and was considered as a medication error occurred. 6. On 5/1/2020 at 0852 hours, Medication Cart 1 was observed unlocked and unattended by the licensed nurse. Five bubble packs (a card where medications are placed in individual clear sealed bubbles) and 14 medication cups filled with tablets and capsules were observed on top of the medication cart. On 5/1/2020 at 0856 hours, an interview was conducted with Staff 1. Staff 1 stated she had been working in the facility for 6 days, on 0700 to 1500 hours shift. Staff 1 acknowledged the medications and medication cart were left unattended and unlocked. Staff 1 also stated she pre-poured the medications scheduled to be administered at 0730 and 0900 hours at the same time because the medications scheduled to be administered at 0730 hours were late. Staff 1 did not give specific reasons as to why the medications were late. Staff 1 was asked if she completed her orientation on the floor, Staff 1 did not provide a verbal response. When asked what medications were given late, Staff 1 pulled out one of the drawers from Medication Cart 1 and showed the bubble packs for the residents which included [MEDICATION NAME] (medication to lower blood sugar), carvedilol (medication to treat high blood pressure and heart failure), [MEDICATION NAME] (medication to lower blood sugar), potassium chloride (supplement) ER (extended release),[MEDICATION NAME](medication used to treat people who cannot digest food normally due to medical conditions), and glimepiride (medication to lower blood sugar). On 5/1/2020 at 1227 hours, an interview was conducted with the DON. The DON was asked if the competency check for medication administration was done with Staff 1. The DON stated the competency check was not done for Staff 1 because the facility did not have enough staff to work on the floor. When asked if the competency check should have been done prior to allowing the staff to work independently on the floor, the DON stated yes because it was needed for the safety of the residents.
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 medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 38%. Three of three licensed nurses (Staff 1, 2, and 8) were found to have made errors during the medication administration. * Resident 6 had the physician's orders [REDACTED]. * Resident 7 had the physician's orders [REDACTED]. * Resident 8 had the physician's orders [REDACTED]. * Resident 9 had a physician's orders [REDACTED]. * Staff 1 was going to administer [MEDICATION NAME] (blood pressure medication) 25 mg to Resident 4 without checking the resident's blood pressure first. * Staff 2 administered four ordered medications beyond the scheduled time for Resident 3. These failures resulted in the resident not receiving the prescribed medications as ordered by the physician, posed the risk of adverse effects, including [MEDICAL CONDITION] (abnormally low blood pressure) for the residents and had the potential to negatively affect the residents' health. Findings: According to the facility's P&P titled Medication Administration - General Guidelines (undated), the medications are to be administered in accordance with the written orders from the attending physician and within 60 minutes of scheduled administration time. 1. On 5/4/2020 at 0800 hours, a medication administration observation for Resident 9 was conducted with Staff 8. Staff 8 prepared and administered Resident 9's medications which included potassium chloride ER 20 mEq tablet. However, review of the Physician order [REDACTED]. The order did not show to administer an extended release tablet. 2. On 5/4/2020 at 0812 hours, a medication administration observation for Resident 8 was conducted with Staff 8. Staff 8 prepared and administered Resident 8's medications which included potassium chloride ER 10 mEq tablet. However, review of the Physician order [REDACTED]. The order did not show to administer an extended release tablet. 3. On 5/4/2020 at 0828 hours, a medication administration observation for Resident 7 was conducted with Staff 8. Staff 8 prepared and administered Resident 7's medications which included TUMS 750 ES (extra strength) one and a half tablets and Tylenol 8 hours Extended Release 650 mg one tablet. However, review of the physician's orders [REDACTED]. Another order dated 6/4/18, was for Tylenol 325 mg two tablets orally twice daily for chronic low back pain. Neither of these medication orders showed to administer extra strength or extended release. One and a half tablets of TUMS 750 ES was equivalent to 1125 mg, which was over 1 gram as ordered. 4. On 5/4/2020 at 0852 hours, a medication administration observation for Resident 6 was conducted with Staff 8. Staff 8 prepared and administered Resident 6's medications which included one tablet of Tylenol 8 hours Extended Release 650 mg tablet. Review of the physician's orders [REDACTED]. The order did not show to administer an extended release tablet. On 5/4/2020 at 1200 hours, an interview was conducted with Staff 8. Staff 8 was asked about the various medications administered. Staff 8 acknowledged Tylenol ER was not the same as the ordered Tylenol, potassium chloride ER was not the same as the ordered potassium chloride tablet, and TUMS was given more than the dosage ordered. One and a half tab of TUMS 750 ES was equivalent to 1125 mg, which was over 1 gram as ordered. According to Staff 8, she only had the supplies of TUMS ES 750 and

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) Tylenol 8 hours Extended Release. On 5/5/20 at 1445 hours, a telephone interview was conducted with the Pharmacy Consultant. The above findings were discussed with the Pharmacy Consultant. The Pharmacy Consultant acknowledged the findings were medication errors and stated the licensed nurses were required to follow the physicians' orders for medication administration. 5. On 5/2/2020 at 0950 hours, a medication administration observation for Resident 4 was conducted with Staff 1. Review of Resident 4's physician's orders [REDACTED]. Staff 1 was observed preparing Resident 4's medication and was about to administer [MEDICATION NAME] without attempting to take the resident's blood pressure. Staff 1 was stopped and informed she had not checked Resident 4's blood pressure. Staff 1 acknowledged the error and stated she should have taken the blood pressure prior to administering the blood pressure medication. 6. On 5/1/2020 at 1051 hours, a medication administration observation for Resident 3 was conducted with Staff 2. Staff 2 administered the following medications at 1051 hours, when they were scheduled to be administered at 0900 hours, to Resident 3: - one tablet of multivitamin, - two tablets of decussate sodium, - one tablet of folic acid 1000 mg, and - one tablet of [MEDICATION NAME] sulfate 325 mg. Review of the Medication Record for May 2020 showed the following medications scheduled to be administered at 0900 hours: - multivitamin one tablet; - decussate sodium two tablets; - folic acid 1 mg one tablet; and - [MEDICATION NAME] sulfate 325 mg one tablet. On 5/1/2020 at 1051 hours, an interview was conducted with Staff 2. Staff 2 acknowledged the four medications she administered to Resident 3 were beyond the scheduled time. Staff 2 stated she had 48 residents to administer the medications during that morning, and it took her a long time to administer all the medications. On 5/5/2020 at 0830 hours, a meeting was conducted with the Administrator, DON, and Nurse Consultant. The Administrator and DON were informed of the medication errors and acknowledged the above findings.
F 0761 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 facility P&P review, the facility failed to ensure the medications were safely stored and accurately labeled as evidenced by: * The facility failed to ensure the key for the medication cart was kept secured and not accessible to unauthorized personnel or residents. * Staff 3 left Medication Cart 1 unlocked and unattended. * Medication Cart 2 was left unlocked and unattended. * The facility failed to ensure the medications were safely stored when Staff 3 left five medication cups containing various medications unattended on top of the medication cart. * Staff 1 was observed administering the medications from three clear unlabeled medication cups filled with various tablets and capsules to the residents. Staff 1 had transferred the medications, including aspirin (antiplatelet), multivitamin (supplement), and [MEDICATION NAME] sodium (stool softener) from their original labeled containers into the unlabeled medication cups. * The facility failed to ensure six of six insulin injector pens were labeled with the correct dosage in accordance with the physician's orders [REDACTED].* Staff 4 left the medication cart unlocked and unattended during the shift change. * Staff 1 left multiple medications unattended on top of the unlocked and unattended medication cart on multiple occasions. These failures posed the risk of unauthorized access, medication administration errors, and drug diversion. On 5/1/2020 at 1418 hours, the IJ situation was identified due to the above deficient practices and on 5/12/2020 at 1050 hours, the IJ situation was abated after the facility had implemented their plan of corrective actions. Findings: Review of the facility's P&P titled Medication Storage in the Facility (undated) showed the medications are to be stored safely, securely, and properly; and to ensure the medication supply is accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Medication rooms, medication carts, and medication supplies are to remain locked or attended by the persons with authorized access. 1. On 4/29/2020 at 1048 hours, Staff 3 was observed placing the medication keys inside the Medication Administration Record [REDACTED]. Staff 3 was observed walking away from the medication cart. There were no staff observed at the nursing station. During this time, three residents were observed passing by the medication cart. On 4/29/2020 at 1145 hours, an interview was conducted with Staff 3. Staff 3 verified he had left the medication keys unattended and unsecured on top of the medication cart. Staff 3 stated the keys provided access to the medication cart which contained the narcotics, and business office. Staff 3 stated he should not have left the keys on top of the medication cart unattended and it was important for the keys to be kept with him at all times. On 5/1/2020 at 1418 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above finding. 2. On 5/2/2020 at 0758 hours, Medication Cart 1 was observed to be unlocked and unattended in the hallway near Room F which was the resident's room. Staff 3 was observed walking out of the resident's room and walking towards the medication cart. Staff 3 verified he had left the medication cart unlocked and unattended while he was inside the resident's room. Staff 3 stated the medication cart should have been locked before he walked away. 3. On 5/3/2020 at 0647 hours, Medication Cart 2 was observed to be unlocked and unattended at Nursing Station 2 . On 5/3/2020 at 0702 hours, an interview was conducted with Staff 8. Staff 8 verified the medication cart was left unlocked and unattended. Staff 8 acknowledged the medication cart should always be locked when unattended by a licensed nurse. 4. On 5/2/2020 at 0758 hours, five clear medication cups filled with various tablets and capsules were observed being left unattended on top of Medication Cart 1. The medication cart was in the hallway on Nursing Station 1 adjacent to the residents' room. Staff 3 stated they had pre-poured the medications which included [MEDICATION NAME] and [MEDICATION NAME], eliquis, vitamins, and Tylenol. Staff 3 acknowledged the above findings. This had the potential for residents to consume these unattended medications, which could have seriously impacted the residents' health and safety. 5. On 5/2/2020 at 0950 hours, a medication administration observation was conducted with Staff 1. When Staff 1 opened the medication cart, three clear unlabeled medication cups observed filled with different colored pill were observed in the top left drawer of the medication cart. When Staff 1 was asked what medications were in the cups, she stated she had taken various amounts of medications from their original house supply containers ([MEDICATION NAME] sodium, aspirin, and multivitamins) and transferred them into the unlabeled cups. Staff 1 stated she did this because it made the medication administration faster and allowed her to not take out the full size bottle each time she prepared the medications. On 5/5/2020 at 0830 hours, a meeting was conducted with the Administrator, DON, and Nurse Consultant to discuss the above finding. The Administrator and DON acknowledged the above finding. 6. Review of the facility's P&P titled Medication Labels (undated), showed inaccurately labeled medications are rejected and returned to the dispensing pharmacy. Medical record review for Resident A was initiated on 5/5/2020. Resident A was admitted to the facility on [DATE]. Review of Resident A's physician's orders [REDACTED]. On 5/5/2020 at 0614 hours, an inspection of Medication Cart 1 was conducted with Staff 4. Resident A's [MEDICATION NAME] pen injector was labeled to inject 45 units subcutaneously daily for breakfast, not 50 units as ordered. On 5/5/2020 at 0645 hours, an inspection of the medication refrigerator and concurrent interview was conducted with Staff 4. Five [MEDICATION NAME] injection pens for Resident A were found being stored in the medication refrigerator. Five of the five [MEDICATION NAME] injection pens were labeled to inject 45 units subcutaneously daily for breakfast, not 50 units as ordered by the physician. Staff 4 verified the this finding and stated the insulin pens should be labeled to inject 50 units. 7. On 5/3/2020 at 0654 hours, Medication Cart 1 was observed being parked in the front lobby area. The medication cart was unlocked and unattended. Two residents were observed passing by the medication cart. Staff 4 was called to the medication cart and asked if it was safe to leave the medication cart unlocked and unattended. Staff 4 stated the medication cart was left unlocked because it was the shift change and the endorsement to the oncoming shift was to be conducted. 8. Review of the facility's P&P titled Medication Storage in the Facility (undated), showed medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier; the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Review of the facility's P&P titled Medication Administration-General Guidelines (undated), showed during administration of the medications, the medication cart is to be kept closed and locked when out of sight of the medication nurse. No medications are to be kept on top of the cart. During multiple observations on 5/1/2020, Medication

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F 0761 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) cart 1 was left unlocked and unattended with multiple medication cups filled with the residents' medications were left unattended on top of Medication Cart 1 as follows: * On 5/1/2020 at 0811 hours, Medication Cart 1 was observed being parked in the hallway in front of Room F which was the resident's room. 17 medication cups filled with various medication tablets and capsule were observed on top of the unattended Medication Cart 1. In addition, the cart had a drawer pulled out which exposed multiple residents' medications. This created an opportunity for unauthorized staff and residents to have full access the medications. * On 5/1/2020 at 0828 hours, Staff 1 was observed in front of Medication Cart 1. Staff 1 removed the blood pressure machine and went inside Room C which was the resident's room. Staff 1 left all of the prepared medications unattended and unsecured. During this time, several residents were observed passing by this medication cart. * On 5/1/2020 at 0837 hours, Staff 1 was observed going inside Room D which was the resident's room. Medication Cart 1 was observed being parked in the hallway outside of another resident room, Room G. 14 medication cups filled with various residents' medications were left unattended on top of the unattended medication cart. There was no licensed nurse in the hallway at this time. * On 5/1/2020 at 0840 hours, Staff 1 was observed walking away from Medication Cart 1 which was parked in the hallway. Staff 1 attended to the resident who was screaming at the end of the hallway. The medication cups filled with various pills were left unattended on top of the unattended medication cart. * On 5/1/2020 at 0842 hours, Staff 1 was observed going inside Room D. Three residents were observed passing by the unattended medication cart which had the medication cups filled with various residents' pills unattended on top of the medication cart. * On 5/1/2020 at 0847 hours, Staff 1 was observed going inside Room D. 14 medication cups filled with various residents' pills were left unattended on top of the unattended and unlocked medication cart. A resident was observed passing by the medication cart at the this time. * On 5/1/2020 at 0852 hours, Staff 1 was observed leaving Medication Cart 1 in the hallway unattended with five bubble packs of the residents' medications and 14 medication cups filled with the residents' pills were observed on top of the unlocked cart. * On 5/1/2020 at 0908 hours, 15 medication cups filled with the residents' pills were left unattended on top of Medication Cart 1 which was unlocked and unattended. When Staff 1 returned to the medication cart, Staff 1 verified the number of medication cups with various medications that were left unattended. The medication cups were labeled with the resident's room numbers for the following 15 residents: Residents 14, G, H, I, J, K, L, N, O, P, Q, R, T, U, and CC. Staff 1 identified the bubble packs included Creon, [MEDICATION NAME] HCL, carvedilol, potassium chloride, [MEDICATION NAME] (antidiabetic medication), and glimepiride. * On 5/1/2020 at 0915 hours, Medication Cart 1 was left unlocked while it was parked in the hallway close to the resident's room, Room H. The unsecured medication cups filled with various medications were on top of the cart in the hallway. On 5/1/2020 at 0935 hours, an interview was conducted with Staff 1. Staff 1 was asked why she left the medication cart unlocked and unattended with the medications unsecured on top of the medication cart. Staff 1 stated she was looking for the residents for the medication administration. Staff 1 acknowledged she should not have left the medication cart unlocked and unattended with the medications unsecured on top of the cart as the residents who passed by could have accidentally taken the unsecured medications from the cart that were not prescribed to them.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure the food sanitary requirements were met in the facility. The facility failed to ensure sanitary conditions of resident's nourishment snacks. This failure had the potential to cause foodborne illnesses in a medically vulnerable resident population. Findings: On 5/3/2020 at 1014 hours, Staff 13 was observed with the nourishment cart in the hallway of Nursing Station 1. 12 opened cartons of house nourishment shakes were observed on the nourishment cart. Each shake carton had an uncovered straw inserted into it. Staff 13 stated she was providing the morning snacks to the residents on Nursing Station 2. Staff 13 was observed placing this nourishment cart up against the wall and hand railing, which caused the uncovered straws to be in direct contact with the hand railing that used by the residents. Staff 13 was asked if the straws should be uncovered and touching the hand railing, Staff 13 responded that they should not. On 5/6/2020 at 1021 hours, Staff 12 was observed with the nourishment cart in the hallway of Nursing Station 2. Approximately 10 unwrapped straws were observed sitting directly on the tray filled with ice water with one end of the straw in the ice water and the other end touching the tray. 14 cartons of house shakes were also observed on the ice tray along with a cup of orange juice. Staff 12 stated she was currently passing out the resident's morning snacks. Staff 12 was asked why the unwrapped straws were placed in the tray and the container of ice water was uncovered. Staff 12 responded she did it this way to keep everything clean for the residents.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility's Administrator failed to ensure the effective oversight and necessary resources were available to meet the resident care services and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in the facility as evidenced by: * The Administrator failed to ensure the CDC's recommendations related to COVID-19 were followed when the visitors were not screened prior to entering the facility and social distancing was not observed for the residents. This failure had the potential for the spread of COVID-19 infection to the residents and staff. * The Administrator failed to ensure the isolation gowns and medications was available in the facility for the resident care. This failure increased the risk of spread of infections. * The Administrator failed to ensure the staff did not cross-contaminate the dirty and clean isolation gowns in order to preserve the use of isolation gowns due to shortage of isolation gowns in the facility. This failure increased the risk of spread of infections. * The Administrator failed to ensure the nursing staff administered the correct dose of the Tylenol medication. This failure had the potential for the residents not receiving appropriate pain management. * The Administrator failed to ensure the nursing staff checked the resident's names prior to administering the medications, ensure the residents took the medications before walking away, and the staff administered the medications timely. This failure had the potential for medication errors. * The Administrator failed to ensure the residents' medications were kept securely and free from unauthorized access. This failure created the risk of the medications being accessed by an unauthorized person. * The Administrator failed to ensure the hand hygiene was performed by the staff between resident care. This failure created the risk of spread of infections. * The Administrator failed to ensure the facility's abuse P&P was implemented when the staff failed to identify and report the incidents of abuse to the Administrator in a timely manner. The SOC 341 report form completed by the Administrator was inaccurate and failed to identify the correct perpetrator and victim. In addition, the Administrator failed to ensure the abuse incidents were reported to the law enforcement. This created the risk of delay in abuse investigation and protecting the residents from abuse. * The Administrator failed to ensure the hired personnel who were permitted to pass the medications and provided care to the residents had the employment screenings for the history of abuse, neglect, and mistreatment prior to hiring. In addition, the newly hired licensed staff' licenses were not verified. This failure created the risk for not protecting the residents from abuse and care being provided by unqualified staff. These cumulative failures contributed to the facility being identified to have the IJ situation on 5/1/2020, related to the safety of the vulnerable elderly residents. Findings: 1. According to the CDC Guidelines in Preparing for COVID-19: Long-term Care Facilities (dated 4/15/2020), guidance includes to restrict the residents to the extent possible to rooms except for medically necessary purposes. If leaving the resident room, the residents should wear a cloth face covering or facemask, limit movement in the facility, and perform social distancing of at least six feet away from others. Facilities must also actively screen anyone entering the building (healthcare provider, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19. a. On 5/5/20 at 0600 hours, two visitors were observed not being screened for signs and symptoms of COVID-19 upon entering the facility. Cross reference to F880, example #8. b. On 4/28/2020 at 1230 hours, approximately 20 to 25 residents were observed standing one to two feet apart from each other without masks or face coverings instead of maintaining six feet social distance. Multiple residents were observed touching each other when approached the elevator. Cross reference to F880, example #1a. c. On 4/28/2020 at 1246 hours, a lunch observation was conducted in the dining room. The residents were observed sitting three to

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F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) four feet apart instead of six feet physical distancing as per the CDC's guidelines. Cross reference to F880, example #1b. 2. On 4/29/2020 at 1340 hours, an observation and concurrent interview was conducted with the DON and Staff 16. Staff 16 counted the disposable isolation gown available in the facility and verified there were 10 disposable isolation gowns. Staff 16 stated she was in charge of ordering the supplies for the facility. Staff 16 stated before the new ownership of the facility a few months ago, she was responsible for ordering the supplies and the items would be delivered the the next day. However, since the change of ownership, the ordering of necessary supplies duty went to Staff A. Staff 16 stated she had repeatedly and frequently requested the supplies (such as PPE including masks, gowns, gloves, and routine house supply medications and vitamins) from Staff A, but the supplies were not received or delivered. The DON verified this information and stated she was aware of obtaining supplies issues and stated she had signed multiple order supply request forms that had been unfilled or partially filled. Review of the New Healthcare Supply Invoice form dated 4/1/20, showed Tylenol 500 mg was requested by the DON. Review of the form titled Supply List showed Tylenol 500 mg was requested by the DON on 4/15, 4/23, and again on 4/28/2020. Documentation showed Tylenol 500 mg tablets noted with a quantity of zero. Review of the Supply List form dated 4/28/2020, showed the disposable isolation gowns (with a quantity of zero) were requested by the DON and a note which read ASAP (as soon as possible) please. On 4/28/2020, during three different interviews conducted with three different staff; Staff 7 at 1150 hours, Staff 3 at 1207 hours, and Staff 16 at 1236 hours, all three staff verified there were no Tylenol 500 mg tablets available in the facility including in the medication carts. Staff 6 stated the supplies had been low for weeks, and was concerned that the facility did not have enough supplies to meet the needs of the residents. On 5/2/2020 at 1145 hours, an interview was conducted with the Administrator. The Administrator presented black trash bags that were cut-outs for a person's arms and head. The Administrator verified these were regular trash bags that he instructed his staff to cut out holes in them for staff to use as the isolation gowns. 3a. On 5/1/2020 at 1040 hours, Staff 1 was observed coming out from the resident's isolation room . Staff 1 was observed placing her used disposable isolation gown on top of the clean disposable isolation gowns inside the isolation cart, which was located outside the resident's room. Staff 1 stated she placed the folded up used gown back into the isolation cart because they did not have enough isolation gowns available in the facility. Cross reference to F880, example #4a. b. On 5/3/2020 at 0950 hours, Staff 13 was observed coming out from the resident's isolation room. Staff 13 placed her used disposable isolation gown on top of the clean gowns in the isolation cart. Staff 13 stated she did this due to the facility not having enough isolation gowns available. Cross reference to F880, example #4b. 4. On 4/29/2020 at 1355 hours, Staff 3 verified on 4/28/2020, he had administered the wrong dose of Tylenol to Resident 15 because he did not have Tylenol 500 mg tablets available. Staff 3 did not contact the physician or document this change in the medication dosage in the resident's medical record. Cross reference to F755, example #2. 5. Staff 1 pre-poured the residents' medications and failed to verify the residents' identification before administering the medications in the dining room to Residents 7 and 11. Cross reference to F755, example #3. 6a. On 5/1/20 from 0811 hours to 0915 hours, Staff 1 was observed multiple times leaving Medication Cart 1 unlocked and unattended with multiple medication cups filled with tablets and capsules on top of the medication cart. Several residents were observed passing by this unlocked and unattended medication cart. Cross reference to F761, example #8. b. On 5/2/2020 at 0748 hours, five clear medication cups with various pills were observed on top of Medication Cart 1. Staff 3 verified the observation and stated the pre-poured medications in the medication cups included [MEDICATION NAME] and atenlol, eliquis, vitamins, and Tylenol. Staff 3 stated the medication cart should have been locked and no medications should have been left unattended. Cross reference to F761, example #4. 7. On 5/1/20 from 0811 hours to 0835 hours, Staff 1 was observed not performing hand hygiene on multiple occasions while administering the residents' medications. Cross reference to F880, example #7. 8a. On 5/1/2020 at 1339 hours, an interview was conducted with the Administrator. The Administrator verified the SSD and DON did not report the altercation between Residents 1 and 2. The Administrator stated the resident to resident altercation had to be reported and investigated. The Administrator verified the investigation was not initiated and the incident was not reported to the state agency, ombudsman, and local enforcement. Cross references to F607, example #1 and F609 example #1. b. The SOC 341 Abuse reporting form was inaccurate and did not show the incident was reported to the law enforcement. Cross reference to F609, example #1. 9. The facility failed to implement their hiring process P&P for conducting the background checks for the new hired staff (Staff 1, 3, 5, and 14) and verifying the licenses for three new hired licensed nurses (Staff 1, 3, and 5) prior to allowing these staff to provide care and/or pass medications to the residents. Cross reference to F607, example #5a.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to maintain the accurate medical records for two of 16 sampled residents (Residents 1 and 5). * Staff 8's documentation for the time Resident 5 was assessed and the attending physician was contacted when the resident complained of skin itching and bug bites were inaccurate. * Staff 2's documentation for the time the NP was informed of Resident 1's left hand bruise was inaccurate. These failures had the potential for the residents' care needs not being met as the clinical information were not accurate. Findings: 1. Medical record review for Resident 5 was initiated on 5/5/2020. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's medical record showed an entry by Staff 8 on 5/5/2020 at 1100 hours, showing the resident had redness and itching to the lower back and the physician was contacted. Review of Resident 5's Physician/NP/PA Communication and Progress Note for New Symptoms, Signs and Other Changes in Condition dated 5/5/2020, showed an entry dated 5/5/2020 at 1600 hours, showing Resident 5 was noted with scattered rashes to the lower back and the attending physician checked the resident with a new order for [MEDICATION NAME] (a topical ointment used to treat skin itching) 1% apply to affected area three times a day until rash was resolved. Another entry dated 5/5/2020 at 1630 hours, showed an order was obtained to transfer Resident 5 to the new room for deep cleaning of her current room. On 5/5/2020 at 1215 hours, an interview and concurrent medical record review was conducted with Staff 8. Staff 8 was asked if Resident 5 had recently voiced any concerns to her about feeling itchy. Staff 8 verified on 5/4 and 5/5/2020, she observed Resident 5 scratched her arms and stated they were very itchy. Staff 8 mimicked the scratching motions made by Resident 5 by scratching both of her arms with her hands. Staff 8 was asked if she considered this was a change of condition. Staff 8 stated this was considered as a change of condition. Staff 8 was asked to describe the process when the resident complained of skin itching. Staff 8 stated she would call the physician, document in the nurses notes on three shifts for three days to monitor the resident, and update the plan of care. When asked why this was not done for Resident 5, Staff 8 stated because the residents at the facility were old and they exaggerated. Staff 8 added the residents wanted attention so they complained. Staff 8 verified Resident 5's medical record failed to show the skin assessment was done, the physician was contacted, and the treatment was provided to address Resident 5's skin itching. Staff 8 stated the treatment was not provided to Resident 5 because she was old and had dry skin. On 5/12/2020 at 1220 hours, a telephone interview was conducted with Staff 8. Staff 8 verified on 5/5/2020, at the time of the interview, no nursing notes, change of condition, and skin assessment had been completed for Resident 5. Staff 8 was asked why the entry on 5/5/2020, was timed at 1100 hours if there was no entry for that time previously. Staff 8 stated she was very busy that week and did not remember what time she notified the physician. Staff 8 stated when she did a late entry for 5/5/2020, she wrote 1100 hours for the time. Staff 8 verified the physician was contacted after the interview on 5/5/2020 at 1215 hours. 2. Review of Resident 1's medical record showed the Physician/NP/PA Communication and Progress Note for New Symptoms, Signs and Other Changes in Condition was initiated on 5/1/2020, by Staff 2. Resident 1's SBAR documentation showed the skin discoloration was observed on the left lower arm. Staff 2 signed the SBAR and dated 5/1/20 at 1100 hours. On 5/1/2020 at 1219 hours, an interview was conducted with Staff 2. Staff 2 verified the change of condition was initiated for Resident 1's left hand and wrist bruises. On 5/12/2020 at 0844 hours, a concurrent interview and medical record review was conducted

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) with Staff 2. When asked about the time the NP was informed about Resident 1's bruise, Staff 2 verified the time written was not accurate. Staff 2 stated she called the NP around 1330 hours instead of 1100 hours.
F 0880 **Level of harm -** Immediate jeopardy **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, medical record review, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infections were implemented as evidenced by: * The facility failed to ensure the CDC's social distancing guidelines (being at least 6-feet away from each other) for COVID-19 were followed during meal times and the use of elevator for the residents. * The DON failed to recognize and report the outbreak of scabies infection in the facility. * The facility failed to ensure staff supervision was provided to prevent the residents from entering the isolation rooms. In addition, the staff failed to ensure Resident I who was observed wandering into the isolation room and touching things in the isolation room performed hand hygiene after leaving the isolation room. * The facility failed to ensure two staff members (Staff 1 and 13) had implemented and performed transmission-based precaution practices. * The facility failed to ensure the staff had access to personal protective equipment and disposal system for the used personal protective equipment at the entrance of the isolation rooms. * Staff 1 failed to perform hand hygiene between the residents' medication administration. * Staff 1 failed to perform hand hygiene and disinfect the blood pressure cuff in between care of the residents. * The facility failed to ensure the visitors were screened prior to entering the facility to prevent the spread of COVID-19 as per the CDC's guidelines. These failures created the risk of transmission of disease-causing microorganisms and spread of infections. On 5/1/2020 at 1418 hours, the IJ situation was identified due to the above deficient practices and on 5/12/2020 at 1050 hours, the IJ situation was abated after the facility had implemented their plan of corrective actions. Findings: 1. Review of the CDC's guidelines for Preparing for COVID-19: Long-term Care Facilities 2020 showed the guidance includes to restrict the residents to the extent possible to rooms except for medically necessary purposes. If leaving the room, residents should wear a cloth face covering or facemask, limit movement in the facility and perform social distancing of at least six feet away from others. a. On 4/28/2020 at 1230 hours, an observation of the facility elevator and concurrent interview was conducted with Staff 7. On the second floor, approximately 20 to 25 residents were observed standing in front of the elevator doors. Residents were observed standing approximately one foot away from one another with multiple residents touching each other as they were approaching the elevator doors. The residents were not observed wearing any face coverings or mask. Staff 7 verified the observation and stated the residents should be maintaining six feet social distance from one another. Staff 7 stated this occurred because the residents had been split up into two groups for communal dining. Staff 7 stated Station 1's residents ate at 1200 hours and Station 2's residents ate at 1230 hours. Staff 7 verified this was a common practice at the facility because residents were used to eating at their assigned time. b. On 4/28/2020 at 1246 hours, the residents were observed in the dining room sitting approximately three to four feet apart from one another at each dining table. Three to four residents were observed sitting together at each table. On 4/28/2020 at 1315 hours, Staff 13 verified the residents were sitting approximately three to four feet apart instead of six feet social distancing as per the CDC's guidelines. Staff 13 stated the residents always sat this way during meal times. On 4/28/2020 at 1320 hours, an interview was conducted with the DON. The DON verified the residents were dining without maintaining the six feet distance from one another. The DON stated the facility implemented the new practice following the COVID-19 guidelines to allow the residents to eat in the dining room at two meal times. The DON stated approximately 40 residents currently were in the dining room at each meal time. The DON was asked how many residents could be in the dining room while maintaining the recommended six feet social distancing guideline. The DON stated only approximately 20 residents could comfortably fit in the dining room while maintaining the six feet distance between each resident. The DON stated the facility had approximately 20 residents in the dining room more than they should have. The DON stated only about two residents should be seated at each dining table to maintain the appropriate distance. The DON was asked why the residents were not able to eat meals in their rooms. The DON stated the facility only had approximately 40 overbed tables. The DON stated for those residents without an overbed table, they would have to place their meal trays on their beds. On 5/1/2020 at 0746 hours, a dining observation was conducted in the dining room. Three to four residents were observed sitting approximately three to four feet apart from one another at each dining table. On 5/2/2020 at 1128 hours, four residents were observed standing approximately three feet apart in front of the elevator. The Administrator verified the observation and guided the residents to keep six feet distance from one another. 2. According to the facility's P&P titled Transmission-Based Precautions and Outbreak Management, undated, outbreak occurs when there are more cases of an infectious disease in a designated population than usually occurring at a given time. Outbreak management includes a quick identification of clusters of infection to be critical. According to the California Department of Public Health Management of Scabies Outbreaks in California Long-Term Care Facilities 2008, infestation of scabies begins when one or several mites are transferred from the skin of an infected person to the skin of an uninfected person. The mites burrow into the surface of the skin and lay eggs and the cycle is repeated over the span of two months. If [DIAGNOSES REDACTED]. Outbreaks should be reported to the local health officer and to the California Department of Public Health, Licensing and Certification District office. One confirmed case and at least two suspected cases occurring among residents should be considered an outbreak for reporting purposes. a. Medical record review for Resident 12 was initiated on 4/29/2020. Resident 12 was admitted to the facility on [DATE]. Review of the facility's Infection Prevention and Control Surveillance Log dated 3/2020 showed an entry for Resident 12 with itchiness and [DIAGNOSES REDACTED]tous skin with the onset date of 2/7/2020, for scabies. Review of Resident 12's physician's Visit Note dated 2/7/2020, showed Resident 12 presented with scabies and linear burrows and [DIAGNOSES REDACTED]tous (abnormal redness of the skin) patches located on the body. A scabies prep (testing to identify mites or their eggs) was performed on the body showing mites. Review of Resident 12's physician's Visit Note dated 3/13/2020, showed Resident 12 presented with scabies on the superior [MEDICATION NAME] spine (portion of the spine that runs from the base of the neck down to the abdomen), left and right forearm, upper sternum, left and right calf, left and right thigh, and right and left pretibial (shin) region. Review of Resident 12's Scabies Treatment order sheet provided by the resident's Dermatologist on 3/13/2020, showed the following orders: - apply [MEDICATION NAME] (antiparasite, medication for scabies) cream for three nights and repeat in two weeks, - administer ivermectin (antiparasite, medication for scabies) 3 mg one tablet daily for three days and repeat in two weeks, - apply [MEDICATION NAME] spray over cleansed surfaces that cannot be washed, and - apply [MEDICATION NAME] cream twice daily to affected areas on body that are inflamed and itchy. Review of Resident 12's Physician's Progress Notes dated 4/8/2020, showed to continue further [MEDICATION NAME] treatment for [REDACTED]. b. Medical record review for Resident 14 was initiated on 4/29/2020. Resident 14 was admitted to the facility on [DATE]. Review of the facility's Infection Prevention and Control Surveillance Log dated 3/2020, showed an entry for Resident 14 with itchiness and [DIAGNOSES REDACTED]tous skin on contact isolation with the onset date of 3/23/2020. Review of Resident 14's Physician's Telephone Orders dated 3/23/2020, showed an order for [REDACTED]. Orders dated 4/8/2020, showed an order for [REDACTED]. Medical record review for Resident 13 was initiated on 4/29/2020. Resident 13 was admitted to the facility on [DATE]. Review of the SBAR dated 4/1/2020, showed the NP was notified of Resident 13's redness on the back of both thighs. The NP ordered [MEDICATION NAME] 0.1% cream twice a day for seven days. Review of the SBAR dated 4/20/2020, showed the NP was notified of Resident 13's rash on the breasts, under the breasts, armpits, lower back, buttocks, and stomach. The NP was notified and ordered [MEDICATION NAME] (an antifungal and corticosteroid cream) 0.05% to be applied twice daily to the affected area for seven days. Review of the Physician's Telephone Orders dated 4/21/2020, showed an order for [REDACTED]. The DON stated the facility had one confirmed case of scabies and two residents with possible scabies diagnosis. The DON verified all three residents were currently on the contact isolation. The DON was asked if she had reported the scabies outbreak. The DON verified she had not. The DON was asked what was considered to be an outbreak of scabies and the DON responded three or more cases of confirmed scabies. On 5/3/2020 at 0810 hours, a follow-up interview was conducted with the DON. The DON was asked if she had reported the scabies outbreak at the facility. The DON verified she had not and would do it tomorrow. 3. On 5/3/2020 at 1000 hours, Resident I was observed walking into Resident 13's contact isolation room. Resident I was observed touching the used isolation gown hanging in the resident's room. Resident I was then observed attempting to close Resident 13's room from the inside. Staff 13 was observed going into Resident 13's room and guiding Resident I back into her own room. Staff 13 stated Resident 13 always wandered, and she tried to keep the resident in her own room. Staff 13 was not observed assisting Resident I to perform hand hygiene. Staff 13 closed Resident I's room and walked away. Staff 13 was stopped and asked if she performed hand hygiene herself or for Resident I. Staff 13 stated she had not because the resident only walked into Resident 13's

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 11) room. On 5/3/2020 at 1010 hours, the Administrator was observed standing in the hallway near room [ROOM NUMBER]. The Administrator was notified of the above observation and Staff 13's interview, and stated it was not an acceptable practice. 4. Review of the CDC's contact precautions guidelines in healthcare settings showed contact precautions are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Guidelines for healthcare personnel caring for patients on contact precautions include wearing a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Review of the facility's P&P titled Transmission Based Precautions and Outbreak Management (undated), under the section, Specific Transmission-Based Precaution: Contact Precaution showed to always clean hands before entering and after leaving the room and to wear gloves and a gown when entering and leaving the resident's room. a. Review of Resident 12's physician's Visit Note dated 2/7/2020, showed the scabies prep was performed on the body showing mites. Review of Resident 12's Physician's Progress Notes dated 4/8/2020, showed the resident required further treatment due to possible resistant scabies. On 5/1/2020 at 0916 hours, Staff 1 who was wearing a surgical mask and a pair of gloves was observed accessing the treatment cart located at Station 1. Staff 1 was observed removing [MEDICATION NAME] 0.1% from the cart and entered Resident 12's room with the same pair of gloves and no isolation gown. An isolation precaution sign was observed posted outside of Resident 12's room alerting healthcare staff to wear mask, gown, and gloves before entering the room. Staff 1 was observed applying the [MEDICATION NAME] 0.10% cream to Resident 12's back. On 5/1/2020 at 1040 hours, Staff 1 who was wearing a pair of gloves was observed accessing the treatment cart located on Station 1. Staff 1 was observed walking to Station 1 and opened the resident's chart wearing the same gloves. Staff 1 was then observed walking towards Resident 12's room. Staff 1 was observed opening one of the drawers from the isolation cart outside Resident 12's room. There were two isolation gowns inside the drawer, one was neatly folded like-new, while the other one was rolled-up and used. Staff 1 picked up and donned the rolled-up and used gown while wearing the same pair of gloves. Staff 1 entered Resident 12's room. When Staff 1 walked out of Resident 12's room, she removed the used gown and placed it back into the isolation cart with the new folded gown. Staff 1 did not remove her gloves but used hand sanitizer on her gloved hands and walked away. Staff 1 verified the above findings and stated she reused the isolation gown because they did not have any more gowns left at the facility. Staff 1 verified the gown she donned before entering Resident 12's room was a used gown and it was okay for her to place it back into the isolation cart with the clean gowns because she did not touch anything in the room. On 5/1/2020 at 1418 hours, an interview was conducted with the DON and the Administrator. The DON and Administrator were informed and acknowledged the above findings. On 5/1/2020 at 1520 hours, an interview was conducted with Staff 1. Staff 1 verified Resident 12's room was the contact isolation room. Staff 1 was asked to describe the process when entering the resident's contact isolation room. Staff 1 stated staff should wear a mask, gown, and gloves. Staff 1 verified she did not wear the isolation gown when she entered Resident 12's room to apply the traimcinolone cream. b. On 5/2/2020 at 1145 hours, an interview was conducted with the Administrator regarding the facility's supply of PPE. The Administrator presented black trash bags with cut-out holes on the sides. The Administrator verified these were regular trash bags that he had his staff cut out holes for the arms to be placed in. The Administrator stated staff would be using these trash bags as the isolation gowns. On 5/2/2020 at 1218 hours, an isolation cart at Resident 12's room was observed with the black trash bags underneath the disposable isolation gowns. On 5/3/2020 at 0950 hours, Staff 13 was observed going out of Resident 12's room. Staff 13 removed her gloves and performed hand hygiene. Staff 13 then removed her isolation gown and placed it back in the isolation cart directly on top of the clean gowns in the cart. Staff 13 verified the observation. Staff 13 stated she was helping Resident 12 in her bed. Staff 13 was asked why she placed the used isolation gown back into the isolation cart. Staff 13 stated because they did not have enough isolation gowns left. Staff 13 verified the black trash bags were also located in the isolation cart that would be worn if they run out of the regular disposable isolation gowns. 5. According to the CDC's Guidelines Implementation of Personal Protective Equipment (PPE) in Nursing Homes 2019, personal protective equipment including gowns and gloves should be available immediately outside of the resident room. Guidance also includes to position trash can inside the resident room and near the exit for discarding of personal protective equipment after removal. a. On 4/28/2020 at 1336 hours, Resident 14's room was observed with the isolation sign posted on the door requiring all healthcare workers to wear mask, gowns, and gloves before entering. There was no trash can was observed near the entrance of the resident's room. On 4/29/2020 at 1050 hours, Resident 14's room was observed with the isolation sign posted on the door requiring all healthcare workers to wear mask, gowns, and gloves before entering. There was no isolation cart nor trash can observed by the entrance of Resident 14's room. b. On 4/28/2020 at 1337 hours, Resident 12's room was observed with the isolation sign posted on the door requiring all healthcare workers to wear mask, gowns, and gloves before entering. There was no isolation cart nor trash can observed by the entrance of Resident 12's room. On 5/1/2020 at 1038 hours, Resident 12's room was observed with the isolation sign posted on the door requiring all healthcare workers to wear mask, gowns, and gloves before entering. There was no trash can observed near the entrance of Resident 12's room. c. On 5/3/2020 at 0949 hours, an observation and concurrent interview was conducted with the Administrator. Resident 13's room was observed with an isolation sign posted on the door requiring all healthcare workers to wear mask, gowns and gloves before entering. A disposable isolation gown was observed hanging at the door handle of Resident 13's closet inside the resident's room. Approximately four inches of the isolation gown was observed touching the floor. The Administrator verified the above findings and stated the isolation gown should not be hung nor touching the floor. On 5/3/2020 at 0950 hours, an interview was conducted with Staff 13. Staff 13 was asked what the current practice was for the contact isolation room. Staff 13 stated when leaving the contact isolation room, she was to throw away her gowns and gloves. Staff 13 verified there was no trash can available to dispose of the isolation gowns near the entrance of Resident 12's room [ROOM NUMBER]. Review of the CDC's hand hygiene guidelines for healthcare providers showed healthcare providers should perform hand hygiene immediately before and after touching a resident or the resident's immediate environment. Review of facility's P&P titled Medication Administration-General Guidelines (undated), showed hands are washed before and after administration of enteral (oral, sublingual or rectal) administration. On 5/2/2020 at 0950 hours, a medication administration observation was conducted with Staff 1. Staff 1 was observed changing the gloves before preparing the medications for Resident 16, but was not observed performing hand hygiene. Staff 1 removed Resident 16's medications from the medication cart and administered the medications to Resident 16. Staff 1 was observed changing the gloves after administering Resident 16's oral medications but was not observed performing hand hygiene. Staff 1 was then observed preparing the medications for Resident 4. Staff 1 administered the oral medications to Resident 4. Staff 1 was observed changing the gloves after administering Resident 4's oral medications but was not observed performing hand hygiene. On 5/2/2020 at 1015 hours, an interview was conducted with Staff 1. Staff 1 acknowledged she changed the gloves before and after administration of the residents' medication. Staff 1 stated she believed her hands were clean even if she only changed her gloves. On 5/5/2020 at 0830 hours, a conference meeting was conducted with the Administrator, DON, and Nurse Consultant. The Administrator and DON were informed and acknowledged the above findings. 7. Review of the CDC's guidelines for Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings showed healthcare personnel should use an alcohol-based hand sanitizer or wash with soap and water before and after touching a patient or the patient's immediate environment, never wear the same pair of gloves in the care of more than one patient, and disinfect the blood pressure cuff prior to use on another patient. a. On 5/1/2020 from 0811 to 0835 hours, Staff 1 was observed passing the medications to the residents from room to room in Station A. The following was observed: - At 0811 hours, Staff 1 was observed entering Room A and wearing a pair of gloves. - At 0814 hours, Staff 1 was observed entering Room B and wearing the same pair of gloves. - At 0825 hours, Staff 1 was observed entering Room C and wearing the same pair of gloves. - At 0835 hours, Staff 1 was observed entering Room D and wearing the same pair of gloves. Staff 1 used the same pair of gloves when she administered the medications to the residents in those rooms. Staff 1 did not perform hand hygiene between the residents. b. On 5/1/2020 at 0835 hours, Staff 1 was observed taking the resident's blood pressure in Room D using the same blood pressure apparatus used for another resident who was in the isolation room for scabies. Staff 1 did not clean the blood pressure cuff between the use for each resident. Staff 1 did not remove her gloves nor performed hand hygiene. On 5/1/2020 at 0853 hours, an interview and concurrent observation was conducted with Staff 1. Staff 1 stated Room A was the contact isolation room for scabies. When asked about hand hygiene in between providing care for the residents, Staff 1 stated she had hand sanitizer but forgot to use it. Staff 1 was then observed putting hand sanitizer on her gloved hands and rubbed the sanitizer on the gloves. When asked how to clean the blood pressure cuff, Staff 1 did not know and did not have disinfection wipes. On 5/1/2020 at 1110 hours, an interview was conducted with the

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) DON. The DON stated Staff 1 should have performed hand hygiene in between the care for the residents and cleaned the blood pressure cuff with the disinfection wipes after each use to prevent the spread of infection. 8. Review of the CDC's guidelines titled Key Strategies to prepare for COVID-19 in Long Term Care Facilities (LTCF), showed the facilities must act immediately to protect residents, families and staff from serious illness, complications and death. Section 1 showed to keep COVID 19 from entering the facility, actively screen anyone entering the building (healthcare provider, ancillary staff, vendors, consultants, etc.) for fever and symptoms of COVID 19. On 5/5/2020 at 0600 hours, two visitors were observed entering the facility after Staff 3 opened the main door and let them in, then Staff 3 walked away. Staff 3 did not screen the two visitors for signs and symptoms of COVID 19. On 5/5/2020 at 0630 hours, an interview was conducted with Staff 3. Staff 3 stated the visitors who entered the facility were to be screened for temperature, signs and symptoms of COVID 19, exposure, and travel history. Staff 3 acknowledged he did not perform the COVID 19 screening on the two visitors who came in the early morning. Staff 3 stated he was just passed by the main entrance area and the staff on the ground level were assigned to do the screening. When asked why the screening was necessary, Staff 3 stated to prevent the residents from getting the COVID 19.