| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **555838** | A. BUILDING _____ B. WING _____ | **03/06/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **CAMDEN POSTACUTE CARE, INC** | **1331 CAMDEN AVENUE CAMPBELL, CA 95008** |

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 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure the responsible party (RP, a person empowered to make decisions for the resident/ person legally responsible and liable for a decision or an action) for one of five sampled residents (Resident 43) was notified when Resident 43 had a change of condition and was transferred to the acute hospital. This failure resulted in staff inability to follow an outlined process for communicating changes in condition to legal representatives or designated family members, which caused extreme anguish and lack of continuity of care for the resident. Findings: Review of Resident 43's clinical record indicated he had the [DIAGNOSES REDACTED]. coordination caused by damaged to the brain and type 2 diabetes (condition that affects the way the body processes blood sugar). Resident 43's minimum data set (MDS, an assessment tool), dated 10/21/19 and 1/20/2020, indicated he had memory problem and severely impaired decision making. During a telephone interview with Resident 43's family member on 3/2/2020 at 11:57 a.m., she stated that facility staff could not get hold of the father when they transferred Resident 43 to the acute hospital on [DATE]. She further stated that other emergency contact family members were not notified of the transfer to the acute hospital until two days after the transfer. Resident 43's family member added that she, herself, was not notified of the transfer until she visited Resident 43 in the facility. She further stated she was very much involved with Resident 43's plan of care and attending care plan conferences for Resident 43 with the approval of the resident's parents because she was living in the area locally and felt bad. Resident 43 was alone in the acute hospital without any family members. Review of Resident 43's Situation, Background, Assessment, Recommendation (SBAR, an assessment tool used to facilitate prompt and appropriate communication of a problem), dated 2/25/2020, indicated Resident 43's gastrostomy tube (GT tube, a surgical opening into the stomach for administration of nutrition and medication) was clogged and he was transferred to the acute hospital. The licensed nurse tried to call Resident 43's RP, but the telephone could not accept any calls. During an interview and concurrent record review with the social service designee (SSD) on 3/3/2020 at 4:30 p.m., the SSD confirmed that Resident 43's face sheet indicated he was admitted to the facility on [DATE] and the responsible party and family emergency contact numbers were listed from contact number 1-5. She further stated that if the first RP emergency contact person could not be reached and staff was not able to notify any change of condition for Resident 43, the 2nd, 3rd, 4th and fifth should have been contacted by the staff. During an interview and concurrent record review with the director of clinical services on 3/3/2020 at 4:19 p.m., she acknowledged the above SBAR and that there was no documentation in the clinical record indicating facility staff notified other emergency contact family members when Resident 43 was sent out to the hospital. She further stated facility staff should have contacted them as indicated on the face sheet. Review of the facility's policy and procedure, Changes in Resident Condition, dated 4/2005, indicated legal representative or designated family members are notified when changes in condition or certain events occur .The resident, attending physician and legal representative or family member are notified when there is: .a significant change in the resident's physical, mental and psychosocial status; .a decision to transfer the resident from the facility and etc. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to develop and implement a resident-centered care plan for three of ten sampled residents (Residents 7, 43 and 20) when: 1. Resident 7's care plan was not developed and revised after she had a fall with major injury, was sent out to the hospital and readmitted back to the facility. 2. Resident 43's non-compliant care plan was not resident centered. 3. Resident 20's care plan was not develop for refusal of range of motion (ROM) and therapy screening. A persolized care plan identifies resident's individualized concerns/needs that outlines the care and services needed to meet their needs. 1. A review of Resident 7's progess notes indicated she had a fall incident on 11/4/19 and sustained an injury and was sent out to acute hospital for further evaluation and management. She was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. and nasal and maxillary fracture (a nasal fracture, commonly referred to as a broken nose, is a fracture of one of the bones of the nose that includes symptoms like bleeding, swelling, bruising, and an inability to breathe through the nose; a maxillary fracutre, a partial or full separation of parts or the entire tooth-bearing part of the maxilla, the jaw or jawbone). During a record review and concurrent interview on 3/3/2020 at 3:24 p.m., with registered nurse B (RN B), RN B reviewed Resident 7's medical record and did not find any interdisciplinary team (IDT) meeting done when Resident 7 was readmitted from the hospital. Resdient 7's fall care plan did not include any new inteventions that addressed resident's fall with injury. RN B stated, an IDT meeting was important to discuss and identify new or added interventions that would prevent Resident 7's further falls or injury; and the care plan should have been updated or revised.<br><br>2. Review of Resident 43's clinical record indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. damaged to the brain). Resident 43's minimum data set (MDS, an assessment tool), dated 10/21/19 and 1/20/2020, indicated he had memory problem, severely impaired decision making, communication problem and had absence of spoken words. During multiple observations on 3/2/2020 at 7:55 a.m., 11:35 a.m., 1:45 p.m., and 3:45 p.m., Resident 43 was lying in bed non-verbal with no eye contact. Both hands were contracted with no contracture devices in both upper and lower extremities. Review of Resident 43's non-compliant care plan, dated 3/28/18, indicated he refused to wear the carrot/towel hand roll on both hands. During an interview on 3/4/2020 at 2:07 p.m., with restorative nursing aid H (RNA H), she stated that Resident 43 had a communication problem and could not talk. She further stated it was hard for the staff to understand if Resident 43 refused to have a carrot/towel on both hands. During an interview on 3/4/2020 at 2:14 p.m., with RNA I, she stated Resident 43 could not talk and it was hard for the staff to understand if he refused to have a carrot/towel on both hands. During a concurrent interview and record review with the director of clinical services on 3/4/2020 at 1:24 p.m., she acknowledged Resident 43's non-compliant care plan was not person centered. She further stated that it should be person centered to address individualized care issues and identified needs. 3. Review of Resident 20's clinical record indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an observation on 3/3/2020 at 9:42 a.m., Resident 20 was lying in bed with contractures on both lower extremities with no device. Resident 20's MDS, dated [DATE] and 12/24/19, indicated he had limited range of motion (ROM, measurement of movement around a joint) on both lower extremities. During a concurrent interview and record review on 3/4/2020 at 11:02 a.m. with DOCS, she confirmed there was |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0656<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>no care plan for contractures of both lower extremities and refusal of ROM or therapy screening for Resident 20. She further stated there should be a person centered care plan to address individualized care issues and identified needs. |
| F 0684<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to provide necessary care and services to one of one residents (Resident 7) when the facility: a) to provide intervention/s to keep Resident 7's skin clean and dry, b) to have a skin care plan related to the right breast and abdominal fold redness, c) to conduct IDT (interdisciplinary team-composed of different disciplines like nursing, etc.) skin meeting, and d) to notify the doctor and responsible party (RP) when staff identified and reported Resident 7's skin redness and rashes. These failures resulted in Resident 7's having pain and discomfort, potential for skin infection and expressed feelings of frustration and embarrassment. During the initial tour on 3/2/2020 at 9:16 a.m., Resident 7 was observed lying on her bed and upon entering her room, there was a bad smell noted, and Resident 7 noted the surveyor's facial expression. Subsequently Resident 7 voluntarily opened her shirt and showed her right breast and the whole abdominal folds which were both noted to be red, raw, and with scattered open areas. The surveyor took a picture of Resident 7's right breast and abdominal folds with Resident 7's verbal consent. Resident 7 stated, the smell is awful and expressed feeling terrible and ashamed, and frustrated the wound was getting worse and painful and nobody was treating it. While still inside Resident 7's room, another surveyor entered the room at 9:20 a.m. When the surveyor commented, smells bad in here, Resident 7 stated, that's me and I'm sorry that is smells bad. Again, Resident 7 lifted the skin folds in her abdomen and right breast and showed the surveyor her skin and indicated it was very painful and apologized for the bad smell. Resident 7 stated, she did not refuse a shower and agreed right away when staff offered to give her a shower. During a follow-up observation and concurrent interview on 3/2/2020 at 10:36 a.m., when licensed vocational nurse A (LVN A), a treatment nurse assessed Resident 7, she confirmed the observation regarding Resident 7's wounds under her right breast and abdominal folds were red, raw, and with open areas that smelled bad. LVN A stated, yes, it smells bad. LVN A stated, the resident needed a treatment order from the doctor. LVN A also stated she was responsible for treatments of non-pressure (i.e skin tear, abrasions, moisture related [MEDICAL CONDITION], etc.) and pressure-related skin problems, and completion of Weekly Skin Evaluations. Review of Resident 7's Nurse's Progress notes and Skin/Wound notes dated November 2019 to March 2020 with LVN A, there were no documentation the MD and RP were notified; no MD order for wound treatment was taken and done; no change of condition (COC) for new skin problem; no care plan; no skin initial assessments/evaluation, and no IDT skin meeting were initiated. LVN A did not find documentation other than treatment and progress notes of redness on left groin dated 6/28/19. Review of Resident 7's treatment administration record (TAR) from November 2019 to March 2020, did not indicate any treatment done to Resident 7's under right breast and abdominal folds. During an interview and concurrent record review on 3/3/2020 at 3:09 p.m. with Registered Nurse B (RN B), and assistant director of nursing (ADON), RN B stated LVN A informed her that Resident 7's wounds were really bad, the certified nursing assistants (CNAs) should have reported to the nurse when they found the skin problem. RN B also stated, Resident 7 needed treatment for [REDACTED]. RN B reviewed Resident 7's progress notes dated 3/2/2020 which indicated, the MD and RP were notified on 3/2/2020 at 9:17 p.m. with treatments ordered for redness on right under breast, abdominal folds and groins (only after the surveyor called staff's attention that morning). A new treatment order dated 3/2/2020 for [MEDICATION NAME] (antifungal) powder apply topically (applied to skin or body surfaces) to abdominal fold, rt. groin and under breast every day shift for moisture-associated skin damage (MASD, is the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus. To prevent MASD, clinicians need to be vigilant both in maintaining optimal skin conditions and in diagnosing and treating minor cases of MASD prior to progression and skin breakdown) was ordered. During an interview on 3/3/2020 at 4:41 p.m., with certified nursing assistant C (CNA C), evening shift CNA, he stated having informed many times (but could not recall the dates) the evening charge nurse and treatment nurse when he and another female CNA first noted Resident 7's skin problems on right under breast and abdominal folds. During a follow-up observation and interview on 3/4/2020 at 7:52 a.m., Resident 7's right breast redness was observed less while under abdominal folds open areas and redness were also less and her pain had decreased and mainly on the right abdomen. Resident 7 stated, the pain had decreased and staff were treating the wound so it was improving. During an interview on 3/5/2020 at 9:40 a.m. with the director of nursing (DON), he stated Resident 7's MD and RP should have been informed of the new skin problems and if Resident 7 refused a shower on 2/25 and 2/28/2020, staff could have cleaned and treated the affected areas to prevent infection and deterioration. The DON concurred the skin problem did not happen overnight and so treatment should have been initiated and documentation of skin problems should have been done when identified. During an interview and concurrent record review on 3/5/2020 at 2:07 p.m., the ADON and medical record staff reviewed Resident 7's medical record from 6/29/19 to 3/2/2020 and did not find any skin assessments/re-evaluation, a situation, background, assessment, recommendation (SBAR, an assessment/reporting tool), weekly IDT skin meeting done regarding Resident 7's identified skin problems under right breast and abdominal folds. Both staff stated, any charge nurse can initiate the skin sheet and SBAR when any new skin problem was identified. The only SBAR done was on 6/29/19 regarding redness on left groin and on 8/16/19 redness of left breast. No other SBAR done. A review of the facility's policy and procedure, Pressure Ulcers/Skin Breakdown-Clinical Skin/Wound Management, dated January 2018, indicated the physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings and application of topical agents if indicated for type of skin alteration. A review of the facility's policy and procedure, Changes in Resident Condition, dated April 2005, indicated the attending physician and legal representative or designated family member are notified when there is a significant change in the resident's physical, mental and psychosocial status using the SBAR. Changes in the resident status that affect the problem(s), goals or approach(es) on his/her care plan are documented as revisions and communicated to the interdisciplinary caregivers. Documentation in the Interdisciplinary Progress Notes include the date, time and Who was notified, information communicated and response and/or orders received. A review of the facility's policy and procedure, Comprehensive Care Plan, dated January 2018, indicated, each resident's comprehensive care plan has been designed to incorporate identified problem areas, reflect treatment goals and objectives, care plans are revised as changes in the resident's condition dictates. |
| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to ensure that the resident environment remains free of accident hazards for one of nine sampled residents (Resident 35) when Resident 35 had a cigarette lighter on top of her tray table in her room. This failure had the potential for accidents to happen and could possibly compromise Resident 35's safety. Findings: A review of Resident 35's [DIAGNOSES REDACTED]. During the initial tour on 3/2/2020 at 8:50 a.m., certified nursing assistant G (CNA G) was inside Resident 35's room assisting her with breakfast, and saw a lighter kit inside an empty cigarette pack on top of Resident 35's tray table. During the concurrent interview with CNA G, she confirmed the observation then put the Resident 35's lighter inside the resident's bag. CNA G stated, residents are not allowed to have lighters. A review of Resident 35's Smoking Safety Screen done on 11/28/19 and 2/28/2020, the assessments indicated the facility needed to store resident's lighter and cigarettes. During an interview on 3/5/2020 at 8:27 a.m., with social service designee (SSD), she stated the resident was not allowed to have a lighter in her possession inside the room or bag for reasons. The SSD also stated the staff who supervised smoking should have taken the lighter after smoking was done. A review of the facility's policy and procedure, Smoking Policy-Residents, dated January 2018, indicated residents who have independent smoking privileges are permitted to keep cigarettes, pipes, tobacco and other smoking articles in their possession. All other forms of lighters, including matches, are prohibited. |
| F 0757<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the failed to act on the medication regimen review recommendation for one of five sampled residents (Resident 46). This failure had the potential for Resident 46 to receive unnecessary medication. |

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| F 0757<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>Findings: A review of the clinical records indicated Resident 46 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, an assessment tool), dated 1/27/2020, indicated Resident 46 was cognitively (ability to understand, learn, remember, and make decisions) intact. During a review of Resident 46's physician orders, dated 7/22/2019, indicated to administer [MEDICATION NAME] suppository 10 milligram (mg. a unit of measurement) one suppository rectally as needed (PRN) and fleet enema 7-19 gm/133 milliliters (ml, a unit of measurement for volume) insert 1 application rectally as needed. A review of Resident 46's pharmacist consultation report dated 1/1/2020 thru 1/17/2020 and 2/1/2020 thru 2/22/2020, indicated to clarify the frequency of the prn bowel care orders fleet enema and [MEDICATION NAME] to indicate how often each order should be given per day. During a concurrent interview and record review on 3/5/2020 at 12:27 p.m., with the registered nurse B (RN B), she acknowledged the above recommendation by the pharmacist consultant and she stated that it was not being followed through by the nursing staff. She further stated that it should have been followed up every month. |
| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary [MEDICAL CONDITION] drugs (medications that are capable of affecting the mind, emotions, and behavior) for two of three sampled residents (Residents 8 and 35) when: 1. Resident 8's documentation of antipyschotic medication side effects monitoring was inaccurate. 2. Resident 35 had did not receive a gradual dose reduction (GDR) for antidepressant medication. These failures resulted in the unnecessary use of [MEDICAL CONDITION] medications. Findings: 1. A review of Resident 8's clinical record indicated admission on 11/22/19 with [DIAGNOSES REDACTED]. of the power of voluntary movement A review of Resident 8's active physician orders [REDACTED].) 5 mg. half tablet by mouth at bedtime for [MEDICAL CONDITION] dated 1/8/2020. During an observation on 3/2/2020 at 12:34 p.m., while eating lunch, Resident 8 was noted with uncontrolled shaking of his hands while holding the bowl and spoon. During a concurrent interview with licensed vocational nurse D (LVN D), she confirmed the observation. She stated Resident 8 had this shaking since he was admitted . During an interview and concurrent record review on 3/5/2020 at 10:00 a.m., with the director of nursing (DON) and registered nurse B (RN B), the DON reviewed Resident 8's Medication Administration Record [REDACTED]. Both RN B and the DON stated, involuntary movements<br>of hands and upper extremities are considered EPS which is one of the side effects of antipsychotic medications. 2. A review of Resident 35 's face sheet indicated admission on 10/4/18 with [DIAGNOSES REDACTED]. Her physician order [REDACTED]. A review of Resident 35's Quarterly interdisciplinary team (IDT, composed of different disciplines like nursing, social service, activities, rehabilitation, dietary, who work together toward a common goal Behavioral Meeting from 7/11/19 to 1/23/2020, indicated one behavior episode documented since admission but no GDR was attempted. During a record review and concurrent interview on 3/5/2020 at 10:49 a.m., with the social service designee (SSD), she confirmed no GDR was done for a year. The SSD stated GDR should have been attemted and if no further behavior then medications should be discontinued. |
| F 0759<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure medication error rates are not 5 percent or greater.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility had 14.81% medication error rate when four medication errors out of 27 opportunities were observed during medication passes for two residents (Residents 11 and 16 ). This failure has the potential to compromised the residents' health and medical condition. Findings: During review of Resident 16's physician orders [REDACTED]. LVN D was about to throw the plastic cup, when the plastic medication cup was noted to contain one half ml (0.5 ml) of pro-stat liquid. LVN D acknowledged the findings. During review of Resident 11's physician orders [REDACTED]. The three tablets were crushed and mixed with applesauce. LVN E administered two scoops of the mixtures and immediately threw the medication cup in the waste container. LVN E was asked to checked the plastic medication cup from the waste container and by using his flash light, LVN E verified the medication cup contained some residue which was approximately one third of the plastic spoon. He also stated, next time. During review of the facility's policy, Administering Medications, dated 1/2008, indicated Medications shall be administered in a safe and timely manner, and as prescribed. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure medication and biologicals were properly labeled, dated, and stored. This failure had the potential to affect resident health and medical condition. Findings: 1. During medication pass observation on 3/2/2020 at 8:37 a.m., an open carton of Resource 2.0 (complete liquid nutritional supplement) on top of the medication cart was undated.<br><br>2. During medication room inspection on 3/2/2020, one prefilled syringe of [MEDICATION NAME] quadrivalent (flu vaccine) was mixed with [MEDICATION NAME] vaccine box (contained 10 prefilled syringes). 3. A multi-dose vial of [MEDICATION NAME] (flu<br>vaccine) was open and dated 11/7/19. 4. One vial of purified protein derivatives (PPD) solution was open and undated. During an interview with the director of staff development (DSD) on 3/2/2020 at 8:48 a.m., she stated, the vial should be labeled and dated upon opening. During a review of the facility's policy, Guide for Special Handling of Medications, dated 1/2013, indicated Multiple dose vials for injection. Discard 28 days after opening. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on observation, interview, and record review, the facility failed to ensure safe food storage practices would be implemented. This failure had the potential to cause food borne illnesses. Findings: During the initial dietary observation on 3/2/2020 at 7:45 a.m., five rotten bananas were found in the fruit basket with two fruit flies noted. Some dried, leftover cooked beef, and two slices of dried turkey were found inside the refrigerator. During an interview with the dietary staff on 3/2/2020 at 8:00 a.m., she agreed on the findings and food items identified were immediately discarded. During a review of an undated facility's policy, Storage of Food Supplies, indicated Food and supplies will be stored properly and in a safe manner. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to ensure the POLST (Physician order [REDACTED]. This failure had the potential for resident to receive incorrect life sustaining treatment and receive medication without the resident or resident representative consent. Review of Resident 43's clinical record indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. type 2 diabetes (high blood sugar). Resident 43's minimum data set (MDS, an assessment<br>tool) dated 10/21/19 and 1/20/2020, indicated he had memory problem and his decision making was severely impaired. Resident |

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| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br>43's POLST dated 9/10/18, indicated it was signed by the physician. The POLST was not signed by the resident or a legally recognized decision maker. Review of Resident 43's physician order [REDACTED]. Review of the facility's policy and procedure, Physician order [REDACTED]. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to assure proper infection control practices was followed when: 1. Resident 43's oxygen cannula (a device used to deliver supplemental oxygen or airflow) and tubing was not labeled; 2. During a medication pass observation Licensed Vocational Nurse D (LVN D) held one tablet with bare hands while cutting the tablet in half; 3. One soiled meal tray was mixed with four clean trays inside the meal tray cart; meal tray cart's door was left open after a meal tray was taken. 4. Resident 36 touched the plastic cups and medication cups kept in the medication cart parked by the hallway with his dirty hands. These deficient practiced had the potential to result in cross-contamination and the spread of infection. Findings: 1. During an initial tour observation on 3/2/2020 at 8:10 a.m., Resident 43's oxygen nasal cannula and tubing was not labeled. During a concurrent observation and interview with the LVN D on 3/2/19 at 8:13 a.m., LVN D confirmed the about observation and she further stated a nasal cannula tubing should have a date. Review of the facility's policy and procedure dated 1/18, Policies and Practices-Infection Control, indicated the objectives of our infection control policies and practices are to: Prevent, detect, investigate, and control infections in the facility; Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.<br><br>2. During a medication pass observation on 3/2/2020 at 9:10 a.m., the licensed vocational nurse D (LVN D) held one tablet with bare hands while cutting the tablet in half. LVN D stated, I should not and immediately discarded the tablet. 3. During meal observation on 3/3/2020 at 12:45 p.m., the activity director (AD) placed one soiled meal tray inside the meal cart mixed with four clean trays. Meal cart's door was left open after a meal tray was taken. The AD acknowledged, took the tray out and closed the meal cart's door.<br><br>4. During an observation on 3/3/2020 at 10:30 a.m., Resident 36 was pacing back and forth in the hallways holding a wash cloth and plastic cup in his hand, spit on the plastic cup, then touched the plastic cups and medicine cups kept in the medication cart part in the hallways. Resident 36 also took sugar [MEDICATION NAME] from the nutrition cart. The director of nursing (DON) who was standing by the hallways was notified and he immediately called the resident's attention. The DON told one female staff who spoke Resident 36's language to explain to resident that he should not be touching things from the cart because his hands were dirty. The charge nurse replaced the medication and plastics cups. |
| F 0911<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.**<br><br>Based on observation and interview, the facility failed to ensure a resident room accommodated no more than four residents when Room A had six beds and six residents and Room B had five beds and five residents. Having more than four residents per room had the potential of compromising the quality of life and quality of care the residents received. Findings: During the survey, six residents were observed in Room A and five residents were observed in Room B. The room had adequate space for the residents to move about and for care to be given. Each resident had a bed, a privacy curtain, a nightstand, and a closet. The beds did not block any closets, bathrooms, or exits. There was no safety hazard or privacy concerns. During interviews with randomly selected residents and staff, there were no quality of care issues identified concerning the size of the room and the number of occupants. Recommend continuance of the room waiver. |
| F 0912<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.**<br><br>Based on observation, interview and record review, the following multi-resident rooms provided less than 80 square feet per resident. Findings: Room Beds Sq Ft/Rm Sq Ft/Res 2 2 146 73 3 2 148 74 4, 5, 6 3 225 75 7 3 222 74 8 2 156 78 9 2 144 72 10, 11, 12, 13 2 146 73 14 2 148 74 15, 16, 17, 18 2 140 70 19 3 228 76 20 3 225 75 21 3 228 76 Room A 6 432 72 Room B 5 323.4 64.68 During observations and staff and resident interviews on 3/2/2020 at 8:13 a.m., and on 3/4/2020 at 1:43 p.m., there were no care issues with the lack of space or privacy identified regarding the size of resident rooms. The residents were observed in their rooms throughout the survey. The nursing care and services were not impacted by the shortage of space. The closet and storage spaces were sufficient to accommodate the needs of the residents. Review of the facility's room variance reports recommend the waiver remain in place. |