STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055758	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH WALK VILLA CONVAL. HOSP.	12350 ROSECRANS NORWALK, CA 90650

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an Advance Directive was documented as offered to residents and/or responsible party for one of 7 residents (Resident 2). This deficient practice had the potential to violate Resident 2 rights when there was no communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions. Findings: A review of the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the History & Physical (H&P) dated 11/08/19 indicated Resident 2 did not have the capacity (ability) to understand and make decisions. The H&P indicated [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), an standardized assessment and care screening tool dated [DATE] indicated Resident 2 had severe cognitive impairment (ability to think, understand and make daily decisions). The MDS indicated Resident 2 had no advanced directive. During a record review on [DATE] at 2:58 p.m., Resident 2's Physician order [REDACTED]. During an interview on 3/12/20 at 10:26 a.m., the Social Services Designee (SSD) stated the advance directives are offered to resident/responsible party upon admission to the facility. The SSD stated there was a specific acknowledgement form to be used indicating information was received by the resident and/or family, on the right to formulate an advanced directive. During a record review on 3/13/20 at 8:52 a.m., no advance directive acknowledgment form was found on Resident 2's physical chart. In a concurrent interview, the SSD stated she would have to check with medical records to see if it was completed. The SSD returned and stated the acknowledgement form may not have been completed by the facility at the time. During a concurrent record review with the SSD, a psychosocial progress note dated [DATE] indicated a POLST review. The SSD was unable to locate documentation that the advance directive had been offered to Resident 2 and/or responsible party. A review of the facility's policy titled, Advance Directives, indicated residents have the right to self-determination regarding their medical care and includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute and advanced directive.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **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 interview and record review, the facility failed to ensure protection from abuse by facility staff for one of one resident (Resident 40) by failing to: 1. Report an injury of unknown origin to law enforcement as indicated by facility policy. 2. Ensure staff received abuse in-service. These deficient practices placed the residents at risk for unsafe conditions and abuse. Findings: A review of the Admission Record indicated Resident 40 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a standardized assessment and care screening tool dated 2/9/20, indicated Resident 40 had severely impaired cognitive skills for daily decision-making and required extensive assistance for activities of daily living (ADL) including bed mobility, transfer, dressing, eating, toilet use and personal hygiene. On 3/10/20 at 12:00 p.m., during an observation and concurrent interview, Resident 40 was non-verbal and had a small discoloration under her eyes. The resident was observed to be unable to turn on her own on the bed. At the bedside, the resident's family member (FM) stated he believed some nurse provided hard care to the resident which caused a bump and redness on middle of forehead which later turned into bruising and discoloration around both eyes. The resident's family member stated he was informed by the facility staff the injuries were due to the resident hitting the bedside table. During an interview on 3/13/20 at 12:25 p.m., the director of nursing (DON) stated an investigation was done regarding the incident with the injury for Resident 40. The DON stated the the injury may have been due to the resident hitting the nightstand while a CNA was turning the resident during care. The DON stated no one has admitted to witnessing or causing the injury to the resident. DON stated the incident was only reported to the ombudsman and department of public health, but not to local enforcement. DON stated he would check the facility's policy regarding reporting requirements if it needed to be reported to law enforcement. On 3/13/20 at 12:54 p.m., during an interview the Administrator (Admin) stated the policy was that injuries of unknown origin should be reported to the state, ombudsman and law enforcement. Admin stated the procedure for reporting allegations of abuse should be followed. On 3/13/20 at 4:10 p.m., during an interview and concurrent record review, the director of staff development (DSD) stated nurse assistant (CNA 2), who was assigned to the resident on the 11 p.m. to 7 a.m. shift the night the injuries were discovered, did not have a current abuse training on file. DSD stated abuse in-service was important to ensure staff knew how to identify, report and handle cases of abuse, as well as to ensure safety of the residents. A review of the facility's policy and procedure titled Reporting Suspected Crimes under the Elder Justice Act Policy last reviewed on 4/15/19, indicated that if there is a reasonable suspicion that a crime has occurred that involves any resident or other individual receiving care, must be reported to local law enforcement and State Survey Agency as soon as practical, but no later than 24 hours, if the person receiving care does not incur a serious bodily injury.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to initiate and developa baseline care plan for one of five residents (Resident 259). This deficient practice placed the resident at risk for inappropriate care and risk for infection. Findings: During an observation on 3/11/20 at 11:49 a.m., Resident 209 with a left wrist saline (solution of salt and water) lock (intermittent access) in place without date, time or nurse initial. Concurrently, Resident 209 stated the intravenous line (IV, thin flexible tube inserted into the vein) had been in for quite some time without use. A review of the Admission Face Sheet indicated Resident 209 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical (H&P) dated 3/4/20 indicated Resident 209 had the capacity to understand and make decisions. The H&P indicated Resident 209 was admitted to the facility with [DIAGNOSES REDACTED]. The H&P also indicated Resident 209 had a history of [REDACTED]. A review of the Physician order [REDACTED]. A physician order [REDACTED]. A review of the Certification and Recertification dated 3/3/20 indicated Resident 209 was admitted to the facility with an IV saline lock. During an interview on 3/12/20 at 9:41 a.m., registered nurse 2 (RN 2) stated an IV saline lock could be in place for four days. RN 2 stated Resident 209 she no longer had a saline lock. RN 2 stated Resident 209 was admitted to the facility with the IV saline lock for antibiotic therapy, but the treatment had been completed. RN 2 stated care plans

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

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) were completed in the EMR and baseline care plans were completed upon admission. During a concurrent review of Resident 209's medical record chart under care plans, RN 2 stated an IV and antibiotic would be initiated on the care plan. RN 2 stated, There is no care plan for the IV and no care plan for the antibiotic, it should be under infection, but it is not here. RN 2 stated the care plan for infection should be checked off because there was a potential for infection. RN 2 stated care plans are important to ensure everyone is aware of what is going on and how to care for the resident. During an interview on 3/12/20 at 11:27 a.m., the Director of Nursing (DON) stated a care plan should be implemented for IV antibiotic therapy to ensure staff are aware and know how to care for the resident. The DON stated an IV in too long creates an increased risk for infection. A review of the facility's care plan titled, Baseline Care Plan, indicated the purpose was to develop a baseline care plan within 48 hours of admission to direct the care team while a comprehensive care plan is developed that incorporated the resident's goals, preferences, and services that are to be furnished to attain or maintain resident's highest practicable physical, mental, and psychosocial well-being. The policy indicated a baseline care plan will be developed for every resident within 48 hours of admission to provide an initial set of instructions needed to provide effective and person-centered care of the resident that meet professional standards of care. The policy indicated update the baseline care plan as needed to reflect current needs until the comprehensive care plan is developed. A review of the facility's policy dated 7/1/12 and titled, Midline Catheter Dressing Change, indicated the nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy within scope of practice. The policy, listed under equipment, indicated a label was used for a dressing change. The policy indicated the procedure for dressing change included a label dressing with the date, time and nurse's initials. The facility had no other intravenous therapy policy.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop a resident centered care plan for four of five residents (Resident 3, 8, 159 and 254). 1. Resident 159 who had uncontrolled pain 2. Resident 3 who had edentulous (lacking teeth) 3. Resident 8 who had a urinary tract infection and extended spectrum beta lactamase (ESBL) resistance (infection from organism resistant to some antibiotics) 4. Resident 259 who was hard of hearing These deficient practices resulted in Resident 159 experiencing pain resulting in the loss of mobility, and resorted to wearing incontinent brief (diaper) because it hurt too much to move, Resident 3 who had difficulty chewing and risk for aspiration, Resident 8 who had the potential for continued infections and Resdient 259 had the potential for continued difficulty with hearing and decreased quality of life. Findings: a. On [DATE] at 8:30 am, during observation and interview, Resident 159 was in bed wearing a an incontinent brief (diaper). Resident 59 had a bedside commode (portable commode) sitting on it between the two room beds. During a concurrent interview, Resident 159 stated had been admitted to the facility yesterday at 3 pm, but did not receive anything for pain since arrival. Resident 159 stated It hurts so bad I can not get out of bed to use the bathroom or the bedside commode. I could get out of bed until last evening since my hospital pain medication wore off. Resident 159 stated had to use diaper at bedtime last night because it hurt too much to move even for a bedpan. Resident 159 stated All they have here for pain is [MED], and that is not enough. It does not help. Resident 159 stated the nurse said would call the doctor for pain medication later this morning after her breakfast. On [DATE] at 4 pm, during a follow up interview, Resident 159 was no longer wearing a diaper but complained of nausea from taking the new pain pill on an empty stomach. On 3/11/20 at 8:00 am, during a follow up interview, Resident 159 stated the new pain pill worked, but still took too long to obtain and it was late in the day until the resident received first dose. During a record review of Resident 59's chart indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. During a review of the hospital records for Resident 159's admission indicate admission [DATE] 8:47 am from a fall at home. The records indicated x-rays (test for broken bones) of face, arms, and legs indicate there was no fracture (broken bones). Resident 59 was hyperglycemic (high blood sugar levels, can result in frequent urination). During a review of the [DATE] facility's admission history and physical indicates admission for rehabilitation following a fall with right leg and bilateral (both) hand pain. The nurse practitioner's medical plan on the history and physical was to monitor pain, assist with activities of daily living (ADL's), and monitor blood sugars. The history and physical shows Resident 59 had capacity to understand and make decisions. During a review of the [DATE] admission history and physical notes for Resident 59 indicated [MEDICATION NAME] (narcotic pain pill) for pain medication. During a review of the [DATE] admission physician orders, there was only a printed recap style sheet of orders signed by Registered Nurse (RN 2). There was no notation on the orders that they were telephonically confirmed with the physician. During a review of the [DATE] electronic orders for Resident 59 included pain scale to be assessed every shift, but the acceptable pain levels line on the order template was not completed. The sole pain medication order indicated was [MED] (non-steroidal anti-[MEDICAL CONDITION] medication for mild pain) 650 milligram (mg) tablets every four hours as needed, for pain, not to exceed 3 grams in 24 hours. During a review of the physician orders [REDACTED]. During a review of physician orders [REDACTED]. Additional orders [DATE] at 5:20 pm indicated [MEDICATION NAME] to right thigh every morning/remove bedtime (topical pain reliever). During an interview with RN 2 on 3/12/20 at 3:30 pm, stated Resident 159 was covered by two of their doctors. RN 2 stated When we get an admission, we document in either the nursing admission assessment or nursing progress notes that we have confirmed the admission orders [REDACTED]. There was no box checked if care plans were reviewed or changed. During a review of care plans for Resident 159, no care plans were available in either the paper or electronic records. During a review of the facility's policy titled, Physician order [REDACTED]. admission orders [REDACTED].) During a review of the facility's policy titled Admission Policy indicated prior to admission the patient will be screened for physical, emotional, and social needs. The referral form will contain signed orders including medications for immediate care available at the time of admission. A physician must provide written orders for the resident's immediate care and needs. During a review of the facility's policy titled Pain Assessment and Management indicated its purpose is to help residents attain their highest practicable level of well-being by proactively identifying, care planning, monitoring, and managing the resident's pain indicators. Based on the comprehensive resident assessment, the facility must ensure the residents receive treatment and care in accordance with professional standards and resident choices. All residents will be assessed for pain upon admission, change of condition, and quarterly. An individualized pain management care plan will be initiated and revised a needed. The facility must provide pain management to residents who require it. b. A review of the Admission record indicated Resident 3 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 2/25/20, indicated Resident 3 had no cognitive (ability to learn, reason, remember, understand and make decisions) impairment and required extensive, one person physical assist for eating. On [DATE] at 9:09 a.m., during an observation and concurrent interview, Resident 3 had edentulous (lacking) teeth. The resident stated she had a difficult time chewing her food and was on a regular diet. On 3/12/20 at 12:59 p.m., during an interview and concurrent record review, Registered Nurse (RN 2) stated Resident 3 was on a regular texture, no added salt diet. RN 2 stated without dentures, the resident had the potential for aspiration (food breathed into airways). RN 2 stated there was no care plan initiated for missing teeth/dentures for the resident. c. A review of the Admission record indicated Resident 8 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 12/16/20, indicated Resident 8 had no cognitive (ability to learn, reason, remember, understand and make decisions) impairment. On 3/13/20 at 11:50 a.m., during an interview and concurrent record review, RN 2 stated Resident 8 had no care plan initiated for ESBL and was started today. d. A review of the Admission record indicated Resident 259 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical dated [DATE] indicated Resident 259 had the capacity to understand and make decisions. On 3/11/20 at 10:46 a.m., during an observation and concurrent interview, Resident 259 did not have eye glasses on and stated she had a difficult time seeing and was hard of hearing. On 3/12/20 at 2:16 p.m., during an interview and concurrent record review, RN 2 stated Resident 259 had a care plan initiated for impaired visual function on 3/11/20 and there was no care plan initiated for hearing impairment. RN 2 stated care plan should have been initiated on admission and was important for continuity of care and for the staff to know how to care for the resident.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and**

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) **prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to revise or update resident care plans for one of 16 sampled residents (Resident 211) with a new [DIAGNOSES REDACTED]. This deficient practice had the potential for the resident to not receive the necessary care and service as evaluated and implemented. Findings: During an observation on 3/11/20 at 11:58 a.m., Resident 211 was observed in bed awake and appeared uncomfortable. During a concurrent interview, Resident 211 stated she had a cough for three days and a UTI. Resident 211 stated she had been using the bathroom often and was uncomfortable. A review of the Admission Record indicated Resident 211 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical (H&P) dated 3/4/20 indicated Resident 211 had the capacity to understand and make decisions. The H&P indicated Resident 211 was admitted for rehabilitation status [REDACTED]. A review of the physician (MD) orders dated [DATE] indicated urine analysis and culture and sensitivity (C&S) for Resident 211. A physician order [REDACTED]. A review of the physician progress notes [REDACTED]. A review of the change of condition (COC) dated [DATE] indicated Resident 211 reported complaints of pain with urination. The COC indicated the physician was notified at 5 p.m. with new orders. During an interview on 3/12/20 at 4:05 p.m., registered nurse 2 (RN 2) stated changes in condition (COC) are documented under assessments. During a concurrent record review indicated the COC dated [DATE] was completed. RN 2 stated Resident 211 was put on [MEDICATION NAME] for suspected UTI. A review of the lab test indicated results were received and viewed on [DATE], showing positive for UTI. During a concurrent interview, RN 2 stated the initials indicated the Nurse Practitioner (NP) viewed the results and the susceptibility was pending. RN 2 stated a care plan would have to be initiated or revised once Resident 211 was diagnosed . RN 2 stated, Actually on [DATE] the result was already checked and the person who initialed in the red stamped circle should have initiated a care plan at that time. During a concurrent review of care plans indicated no revision was completed for UTI. RN 2 stated, Yes, a care plan should have been completed so everyone was aware of what is going on with Resident 211. During an interview on 3/12/20 at 4:17 p.m., licensed vocational nurse (LVN 6) stated a COC was documented in the SBAR (Situation, Background, Assessment, Recommendation). During a concurrent record review, LVN 6 presented the COC, lab initiated, results received on [DATE], notes calling the Nurse Practitioner (NP) and starting [MEDICATION NAME] antibiotic. LVN 6 stated a care plan was important to identify the interventions would be implemented; handwashing, peri-care, hydration, antibiotic as orders, monitoring for urine output (color, odor, amount), monitoring for pain and/or discomfort. LVN 6 stated the physician was to be called if intervention was not effective and the plan of care would need to be readjusted. LVN 6 stated there was no care plan for UTI. The facility did not provide a copy of the facility policy for Comprehensive Care Plan.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to adhere to the current standard of nursing practice and professional standards of quality for six of six residents (7, 8, 14, 56, 209 and 259) by failing to: 1. Perform patient identifier verifications per policy during medication administration for Residents 7, 14 and 56. 2. Date, time, initial and/or change the midline catheter (thin tube inserted in a larger vein) dressing for Residents 8 and 259 per physician's orders [REDACTED]. Date and time an intravenous (IV) site dressing and discontinuing or rotating an IV site for Resident 209. These deficient practices had the potential to result in medication error for Residents 7, 14 and 56, missed dressing changes, infection and complications related to IV therapy for Residents 8, 229 and 259. Findings: a. On 3/12/20 at 7:57 a.m., during medication administration observation and concurrent interview, licensed vocational nurse (LVN 3) was observed administering [MEDICATION NAME] (medication used to control abnormal blood sugar) 500 milligrams (mg, unit of weight) to Resident 7. On 3/12/20 at 8:06 a.m, licensed vocational nurse (LVN 3) was observed administering [MEDICATION NAME] 5/325 mg to Resident 56. On 3/12/20 at 8:32 a.m., licensed vocational nurse (LVN 3) was observed administering [MEDICATION NAME] 18 micrograms, unit of weight) mcg capsule, [MEDICATION NAME] sodium 100 mg., [MEDICATION NAME] sulfate 325 mg., and [MED] 5mg to Resident 14. LVN 3 stated he addressed the residents by their names however did not follow the proper protocol of verifying the resident's identifiers including checking the residents' identification (ID) band if available, asking the resident to state their names or asking a co-worker to assist in verifying the residents identity. LVN 3 stated it was the facility's policy to verify resident's identifier prior to medication administration and it was important to do so to prevent medication errors. On 3/12/20 at 9:34 a.m. during an interview, the director of nursing (DON) stated, nurses have to follow the five rights which includes the right patient and is important to prevent medication errors and to ensure that the nurse was administering the right medication to the right resident. A review of the facility's policy and procedure titled, Identification of Residents Prior to Administering Medications and Providing Treatments or Procedures last reviewed on [DATE]5/19, indicated that residents are identified using two identifiers prior to administering medications which included asking the resident his/her full name and compare it to the name on the medication administration record (MAR) and compare the resident's photo to the resident, if an armband is in use, compare the name on the arm band to the name on the MAR and compare the resident's photo to the resident, if there is no photo or arm band, and the resident is unable to tell you his/her full name, then validate the resident's identity with a second associate who is familiar with the resident and compare the resident's name to the MAR. b. A review of the Admission Record, indicated Resident 8 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 12/16/20, indicated Resident 8 had no cognitive (ability to learn, reason, remember, understand and make decisions) impairment. On [DATE] at 8:42 a.m., during an observation midline catheter noted to left upper arm was not dated or labeled. On 3/11/20 at 1:39 p.m., during a witnessed observation and interview, registered nurse (RN 2) stated the midline catheter was inserted last week at the facility by the pharmacy IV team however was unable to remember the exact date it was inserted. RN 2 stated that Resident 8's dressing had no date or label and the facility policy was to change the dressing every 7 days or when soiled or peeling off. RN 2 stated it was important to label in order to determine whether the dressing needed to be changed. RN 2 stated Resident 8's dressing needed to be changed. On 3/12/20 at 3:18 p.m., during an interview and concurrent record review, RN 2 stated facility's policy was to follow guidelines as per Vic the PICC Nursing Care for Midline Catheter. The dressing change order was to be done on one day after insertion which should have been on 3/6/20 however was not done until 3/11/20 at 2:36 p.m. c. A review of the Admission Record, indicated Resident 259 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical dated [DATE] indicated Resident 259 had the capacity to understand and make decisions. On [DATE] at 8:39 a.m., during an observation and concurrent interview, Resident 259 noted with a midline catheter to the right upper arm, dated 3/6/20 and but not initialed nor timed. The resident stated the IV was started at the hospital and that it has not been changed since she has arrived at the facility. On 3/11/20 at 3:30 p.m., during a witnessed observation, licensed vocational nurse (LVN 9) stated resident 259's dressing was labeled with a date of 3/6/20. On 3/12/20 at 10:15 a.m., during an interview and concurrent record review, the MAR for Resident 259 indicated the dressing was changed on 3/09/20 by LVN 9, however stated she had not changed the dressing. On 3/12/20 at 10:24 a.m., during an interview and concurrent record review, a physician's orders [REDACTED]. RN 2 stated she was not sure why it was documented was done with her initials on 3/10 at 2:03 p.m., however she had not changed the dressing. On 3/12/20 at 10:31 a.m., during an interview and concurrent record review, the DON stated the facility policy was to date, time and initial midline catheter dressings and that the dressings should be changed per physician's orders [REDACTED]. DON stated these are done to ensure the IV sites are being monitored, the dressings are being changed in a timely manner and to help prevent infiltration and infection. A review of the facility's policies and procedures titled, Midline Catheter Dressing Change, last revised on [DATE]/12, indicated sterile dressing changes should be changed every 24 hours post insertion or upon admission, at least weekly or if the integrity of the dressing has been compromised (wet, loose or soiled) and that dressing should be labeled with date, time and nurse's initials. d. During an observation on 3/11/20 at 11:49 a.m., Resident 209 was observed with a left wrist saline (solution of salt and water) lock (intermittent access) in place without date, time or nurse initial. During a concurrent interview, Resident 209 stated the intravenous line (IV, thin flexible tube inserted into the vein) had been in for quite some time without use. A review of the Admission Record indicated Resident 209 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical (H&P) dated 3/4/20 indicated Resident 209 had the capacity to understand and make

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) decisions. The H&P indicated Resident 209 was admitted to the facility for rehabilitation and treatment due [MEDICAL CONDITION] secondary to acute [MEDICATION NAME] (obstruction of cystic duct), status [REDACTED]. The H&P also indicated Resident 209 had a history of [REDACTED]. A review of the Physician order [REDACTED]. A physician order [REDACTED]. A review of the Progress Notes for Resident 209 dated 3/4/20, 3/5/20, 3/6/20, 3/7/20, 3/8/20, [DATE] and 3/11/20 indicated IV saline lock site (location) assessed (checked). A review of the Certification and Recertification dated 3/3/20 indicated Resident 209 was admitted to the facility with an IV saline lock. During an interview on 3/12/20 at 9:41 a.m., registered nurse 2 (RN 2) stated an IV saline lock could be in place for four days. RN 2 stated Resident 209 she no longer had a saline lock. RN 2 stated Resident 209 was admitted to the facility with the IV saline lock for antibiotics, but the treatment was completed. RN 2 stated the date, time, and initials were written on the dressing. RN 2 stated, Resident 209 was admitted on [DATE] and today was 3/12/20, I don't think it is appropriate, the IV has been in too long. RN 2 stated the IV could get infiltrated (inadvertent administration of fluid or medication into surrounding tissues) and infected. RN 2 stated the IV saline lock should have been discontinued once the antibiotic treatment was completed. During an interview on 3/12/20 at 11:27 a.m., the director of nursing (DON) stated infusion therapy may be order 5-7 days. The DON stated intravenous site (IV) of insertion are monitored for signs of swelling, infection, and patency. The DON stated on the transparent dressing after insertion, the nurse will write the date, time and initials. The DON stated the time and date are important to ensure others are aware. The DON stated once the therapy was completed a call was placed to the physician. The DON stated a physician order [REDACTED]. The DON stated there was a risk for infection if the IV saline lock stayed in too long. A review of the facility's policy dated 7/1/12 and titled, Midline Catheter Dressing Change, indicated the nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy within scope of practice. The policy, listed under equipment, indicated a label was used for a dressing change. The policy indicated the procedure for dressing change included a label dressing with the date, time and nurse's initials. The facility had no other Intravenous Therapy policy. According to the Centers of Disease (CDC), peripheral catheters should be changed out within 72-96 hours to reduce risk of infection and phlebitis in adults. Retrieved on 3/18/20 from https://www.cdc.gov/infectioncontrol/guidelines/bsi/recommendations.html
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide on-going activities which meet the resident's preferences and interests based on the comprehensive assessment for one of one resident (Resident 33). This deficient practice had the potential to cause psychosocial harm and feelings of isolation for Resident 33. Findings: A review of the Admission record, indicated Resident 33 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to perform everyday activities) and anxiety disorder. A review of Minimum Data Set (MDS) a standardized assessment and care screening tool dated 5/1[DATE]9, indicated the resident had moderately impaired cognitive skills for daily decision-making and required extensive assistance from staff for activities of daily living (ADL's) including bed mobility, transfer, dressing, eating, toilet use and personal hygiene and was totally dependent on staff for locomotion off unit (how resident moves to and from distant areas on the floor). A review of the History and Physical (H&P) dated 8/9/19, indicated Resident 33 was on hospice care (type of health care that focuses on a terminally ill resident's pain and symptoms and attending to their emotional and spiritual needs at the end of life). On 3/11/20 at 1:18 p.m., during an observation, Resident 33 was lying in bed, awake, starring up towards the ceiling, television was off and no staff at bedside. On 3/12/20 at 10:55 a.m., during an interview and concurrent record review, activities director (AD) stated Activities Evaluation (ACT) dated 5/9/19 indicated Resident 33's current interests included current events/news, group discussion, movies, music, religious services, sports and television. The ACT indicated resident to be up for activities of choice at least three times (3x) a week as tolerated. Documentation of activities provided and attended for the resident documented on Record of one-to-one activities indicated the resident had no activities offered or participated to include current events/news, movies and sports. AD stated the resident did participate in group discussion once in a three month period (from 1/1/20 to 3/13/20) which included reminiscing about football on [DATE]. The resident participated once in a three month period in religious services on 2/9/20. Activities record indicated room and activities visits done on 1/5/20, 1/18/20, 1/22/20, 1/31/20, 3/6/20 and 3/8/20 however the resident was asleep. AD stated that if activities staff or volunteer is unable to reach resident at a particular time, the staff or volunteer should try at a later time and this was not done for the resident. AD stated it was important to schedule another time to ensure that the resident's activities needs are being met and the resident was seen when he was more alert and able to engage in the activities he would enjoy. A review of the facility's policy and procedure, Components of a Therapeutic Recreation Program dated 8/21/19, indicated recreations for residents with dementia must be individualized and customized based on the resident's previous lifestyle, preferences and comforts.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, interview and record review, the facility failed to provide restorative nursing assistant (RNA) program intervention with a hand splint (rigid or flexible device that maintains in position a displaced or movable part) per physician's orders [REDACTED]. This deficient practice had the potential to cause further contractures (condition of shortening and hardening of muscles, tendons or other tissue often leading to deformity and rigidity of joints) for Resident 3. Findings: A review of the Admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a standardized assessment and care screening tool dated 2/25/20, indicated Resident 3 had no cognitive (ability to learn, reason, remember, understand and make decisions) impairment, was totally dependent on staff for transfers (how resident moves between surfaces including to and from bed, chair, and wheelchair) and required extensive assist for activities of daily living including bed mobility, dressing, eating toilet use and personal hygiene. On [DATE] at 9:07 a.m., during an observation and concurrent interview, Resident 3 was unable to lift or move left upper (LUE) and lower extremities (LLE) (arms and legs). The resident stated she was paralyzed on the left side from a stroke. The resident did not have a splint or brace on and stated, the last time a splint was placed was a week ago and that the splint was not put on every day. On 3/12/20 at 3:18 p.m., during an interview and concurrent record review, restorative nurse assistant (RNA 1) stated the physician's orders [REDACTED]. RNA 1 stated daily charting was done in Point Click Care (PCC, electronic health record) system, however the order was not entered into PCC, therefore no daily charting was found for splinting for the resident. A review of RNA weekly summary dated 3/12/20, indicated Resident 3 was to receive a hand splint for LUE to prevent from further contracture. There was no documentation to specify splint was placed daily as ordered. On 3/13/20 at 9:36 a.m., during an interview, the director of rehab (DOR) stated splinting helped to prevent further contractures. A review of the facility's Policy and Procedures titled, Restorative Nursing dated 5/16/19 indicated that the facility is responsible for providing maintenance and restorative programs to achieve and maintain the highest practicable (highest possible level of functioning) outcome.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify, care plan, and provide services to maintain continence for one of five residents (159). This deficient practice resulted in Resident 159 experiencing the loss of continence, due to inadequate pain control. Findings: During an observation on [DATE] at 8:30 a.m., Resident 159 was observed in bed wearing an incontinent pad (diaper). During a concurrent interview, Resident 159 stated was admitted to the facility at 3 p.m. the previous day in the afternoon and have received nothing for pain since arrival. The resident stated her pain was so bad, she could not get out of bed to use the bathroom or the bedside commode. Resident 159 stated she had to use a diaper at bedtime the previous night because it hurt too much to move even to use a bedpan. Resident 159 stated she does not like to use a diaper because it makes her feel bad and she did not need it. During an interview on 3/11/20 at 8:00 a.m., Resident 159 stated her newly prescribed pain pill worked, but was late in the day until she received

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	055758	A. BUILDING _____ B. WING _____	03/13/2020

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) first dose. The resident stated after the pain was controlled [DATE], Resident 159 stated no longer wore a diaper, was continent, and got up to go to the bathroom with assistance. A review of Resident 159's medical record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 159's History and Physical (H&P) indicated the resident was admitted to the facility for rehabilitation following a fall with right leg and bilateral (both) hand pain. The nurse practitioner's medical plan on the history and physical was to monitor pain, assist with activities of daily living (ADL's), and monitor blood sugars. The history and physical indicated Resident 159 has capacity to understand and make decisions. A review of Resident 159's electronic physician orders [REDACTED]. The only pain medication order was for [MED] (non-steroidal anti-[MEDICAL CONDITION] medication for mild pain), 650 milligrams (mg, unit of weight) tablets every four hours as needed for pain not to exceed 3 grams in 24 hours. A review of the physician orders [REDACTED]. During a review of physician orders [REDACTED]. Additional orders [DATE] at 5:20 p.m. indicate [MEDICATION NAME] (topical pain reliever) patch to right thigh every morning and remove bedtime. A review of orders dated 3/12/20 at 7:24 a.m. indicate that Resident 159 may use bedside commode (portable bedside commode) due to status [REDACTED]. A review of the 3/12/20 care plan conference record with Resident 159 and the interdisciplinary team, there was no box checked if care plans were reviewed or changed. During a review of care plans for Resident 159, no care plans were available in either the paper or electronic records. During a review of the policy titled, Physician order [REDACTED]. admission orders [REDACTED].) A review of the policy Incontinence Management, Urinary, Long Term Care indicates the facility is to conduct a comprehensive interdisciplinary review and assessment of resident's continence status on admission, quarterly and with significant change of urinary function including factors that predispose the resident to the development of incontinence. Develop an individualized care plan based on assessment findings and as needed. Assess the resident with incontinence for an underlying disorder.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper care and services for one of two residents (Resident 37) who was receiving gastrostomy tube (GT-tube that is passed through the abdominal wall to the stomach used to provide nutrition) feeding by: 1. Failing to provide the total volume ordered was received per physician's orders [REDACTED]. These deficient practices had the potential to result in altered nutrition status and bacterial contamination for Resident 37. Findings: A review of the Admission record indicated Resident 37 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a standardized assessment and care screening tool dated 1/27/20, indicated Resident 37 was severely impaired cognitive skills for daily decision-making and was totally dependent on staff for transfer (how resident moves between surfaces including to or from bed, chair, wheelchair) and eating. On [DATE] at 9:54 a.m., Resident 37 was observed with [MEDICATION NAME] 1.2 cal tube feeding hanging at bedside and feeding pump was off. The tube feeding formula volume was full, dated and timed on [DATE] at 1:00 p.m. The tubing on the administration set not labeled. On [DATE] at 1:16 p.m., Resident 37's tube feeding was observed to be on and set to run at 50 cubic centimeters (cc, unit of volume) per hour. On 3/11/20 at 10:29 a.m., Resident 37's tube feeding was observed to be off. The [MEDICATION NAME] bottle was dated and timed on [DATE] at 1:00 p.m. was hanging, the tubing was dated [DATE] at 1:00 p.m. and 250 cc of tube feeding formula was left in the bottle. On 3/11/20 at 3:57 p.m., during an observation and interview, license vocational nurse (LVN 4) stated Resident 57's tube feeding bottle was [MEDICATION NAME] 1.2 dated and timed [DATE] at 1:00 p.m., with a rate of 50 cc/hour. Less than 200 cc was left in bottle however the infusion pump indicated 142 cc infused and 863 ml left. LVN 4 stated the bottle of tube feeding had been used over 27 hours and should have been completed in 20 hours or by 9:00 a.m. since it was dated to be hung at 1:00 p.m. on [DATE]. LVN 4 stated the physician's orders [REDACTED]. LVN 4 stated the feeding was not held since [DATE] according to the documentation. On 3/13/20 at 9:58 a.m., Resident 37's tube feeding was observed to be off, bottle dated 3/12/20 at 1:00 p.m., 250 cc was left in bottle. On 3/13/20 at 11:15 a.m., LVN 7 stated she had stopped the tube feeding for Resident 37 at 9:00 a.m. and discarded the bottle with about 120 cc left in the bottle. LVN 7 stated she had always stopped the feedings at 9:00 a.m. on her shifts even when there was remaining feeding volume in the bottle. On 3/13/20 at 11:32 a.m., during an interview and concurrent record review, RN 2 stated if the feeding was stopped at 9:00 a.m. and there was volume left in the bottle, Resident 37 would not be receiving her calories as calculated and ordered for her and she would not be receiving all the nutrition requirements. A review of manufacturer's recommendations indicated [MEDICATION NAME] bottle may be hung up to 48 hours after initial connection and only one new feeding set are used. Otherwise, hang no longer than 24 hours. Kangaroo Epump Enplus Spike Set manufacturer's recommendations indicated the administration set should not be used greater than 24 hours. A review of the facility's policy and procedure titled, Feeding tubes (Gastrostomy, Jejunostomy, Transgastric Jejunal) last reviewed on [DATE]5/19 indicated the facility will provide care and services related to feeding tubes according to the resident's needs/wishes and clinical practice standards.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, care plan, and provide adequate pain management to control one of 5 residents (59), who was experiencing pain. This deficient practice resulted in Resident 59 experiencing pain resulting in the loss of mobility, and resorted to wearing incontinent brief (diaper) because it hurt too much to move. Findings: On [DATE] at 8:30 am, during observation and interview, Resident 59 was in bed wearing a an incontinent brief (diaper). Resident 59 had a bedside commode (portable commode) sitting on it between the two room beds. During a concurrent interview, Resident 59 stated had been admitted to the facility yesterday at 3 pm, but did not receive anything for pain since arrival. Resident 59 stated It hurts so bad I can not get out of bed to use the bathroom or the bedside commode. I could get out of bed until last evening since my hospital pain medication wore off. Resident 59 stated had to use diaper at bedtime last night because it hurt too much to move even for a bedpan. Resident 59 stated All they have here for pain is [MED], and that is not enough. It does not help. Resident 59 stated the nurse said would call the doctor for pain medication later this morning after her breakfast. On [DATE] at 4 pm, during a follow up interview, Resident 59 was no longer wearing a diaper but complained of nausea from taking the new pain pill on an empty stomach. On 3/11/20 at 8:00 am, during a follow up interview, Resident 59 stated the new pain pill worked, but still took too long to obtain and it was late in the day until the resident received first dose. During a record review of Resident 59's chart indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. During a review of the hospital records for Resident 59's admission indicate admission [DATE] 8:47 am from a fall at home. The records indicated x-rays (test for broken bones) of face, arms, and legs indicate there was no fracture (broken bones). Resident 59 was hyperglycemic (high blood sugar levels, can result in frequent urination). During a review of the [DATE] facility's admission history and physical indicates admission for rehabilitation following a fall with right leg and bilateral (both) hand pain. The nurse practitioner's medical plan on the history and physical was to monitor pain, assist with activities of daily living (ADL's), and monitor blood sugars. The history and physical shows Resident 59 had capacity to understand and make decisions. During a review of the [DATE] admission history and physical notes for Resident 59 indicated [MEDICATION NAME] (narcotic pain pill) for pain medication. During a review of the [DATE] admission physician orders, there was only a printed recap style sheet of orders signed by Registered Nurse (RN 2). There was no notation on the orders that they were telephonically confirmed with the physician. During a review of the [DATE] electronic orders for Resident 59 included pain scale to be assessed every shift, but the acceptable pain levels line on the order template was not completed. The sole pain medication order indicated was [MED] (non-steroidal anti-[MEDICAL CONDITION] medication for mild pain) 650 milligram (mg) tablets every four hours as needed, for pain, not to exceed 3 grams in 24 hours. During a review of the physician orders [REDACTED]. During a review of physician orders [REDACTED]. Additional orders [DATE] at 5:20 pm indicated [MEDICATION NAME] to right thigh every morning/remove bedtime (topical pain reliever). During an interview with RN 2 on 3/12/20 at 3:30 pm, stated Resident 59 was covered by two of their doctors. RN 2 stated When we get an admission, we document in either the nursing admission assessment or nursing progress notes that we have confirmed the admission orders [REDACTED]. There was no box checked if care plans were reviewed or changed. During a review of care plans for Resident 59, no care plans were available in either the paper or electronic records. During a review of the facility's policy titled, Physician order [REDACTED]. admission orders [REDACTED].) During a review of the facility's policy titled Admission Policy

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) indicated prior to admission the patient will be screened for physical, emotional, and social needs. The referral form will contain signed orders including medications for immediate care available at the time of admission. A physician must provide written orders for the resident's immediate care and needs. During a review of the facility's policy titled Pain Assessment and Management indicated its purpose is to help residents attain their highest practicable level of well-being by proactively identifying, care planning, monitoring, and managing the resident's pain indicators. Based on the comprehensive resident assessment, the facility must ensure the residents receive treatment and care in accordance with professional standards and resident choices. All residents will be assessed for pain upon admission, change of condition, and quarterly. An individualized pain management care plan will be initiated and revised a needed. The facility must provide pain management to residents who require it.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on observation and interview, the facility failed to post nurse staffing information on a daily basis at the beginning of each shift. This deficient practice had the potential for the residents, and visitors not know if there was sufficient staffing to provide nursing care to the residents. Findings: During an observation on [DATE] at 11:00 a.m., nursing staffing information posted was not updated and indicated staffing information dated [DATE]. During an interview on [DATE] at 11:45 a.m., the Director of Nursing (DON) stated nurse staffing information must be accurate to ensure appropriate staffing to care for the residents. Concurrently, DON showed nurse staffing posting and the DON stated the staffing information should be updated daily first thing in the morning. The DON stated that we even had two posted signs.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility to provide pharmacy services for two of 16 residents (45, 160), by ensuring: Resident 45, the facility did not keep an accurate account of administered doses of controlled medications on the Controlled or Antibiotic Drug Record ((CDR) a log signed by the nurse with the date and time each time a controlled substance is given to a resident) Resident 160, the Physician order [REDACTED]. needed, and puts the facility at increased risk for the potential loss, diversion (transfer of a medication form, a legal to an illegal use), or accidental exposure to controlled substances. Findings: a. During an accompanied inspection and interview on [DATE] at 11:54 a.m., the Director of Nursing (DON) presented process of disposal of controlled substances. A concurrent review of the controlled substance (a drug or other substance that is tightly controlled by the government) inventory form dated [DATE] indicated a missing witnessed signature. Concurrently, the DON stated the second signature was required to witness the disposition/disposal of controlled medications. The DON stated, The Pharmacist and DON are supposed to sign when destroying controlled medications. The DON stated if there was no signature there was a chance of diversion of medication. DON continued reviewing the records and stated the importance of a witnessed signature and it was unacceptable for the nurse not to follow the process. The records indicated there was no co-signature for February 2020, [DATE], and [DATE]. DON acknowledged and identified the following: 1. Record of Product Destruction dated [DATE] indicated pharmacist signature missing second witness signature. 2. Record of Product Destruction dated [DATE] indicated pharmacist signature missing second witness signature. 3. 15 inventory sheets of Controlled or Antibiotic Drug Records for February 2020 missing Registered Nurse signature for month of February 2020. 4. 15 inventory sheets of Controlled or Antibiotic Drug Records, 14 missing Registered Nurse signature and one sheet missing RN and Pharmacist Signature for the month of [DATE]. During an interview on [DATE] at 12:53 p.m., the Pharmacy Consultant (PC) stated, The DON will print out the Controlled Substance Inventory report, we check each drug sheet, one by one for discrepancy and I sign and the DON usually signs. The PC stated there are two signature areas on the form. The PC stated, I destroy the controlled medications with the DON and we both sign the page. The PC stated it was important to have two signatures because one person destroys the medication and one was a witness to the destruction, to ensure there are no issues. The PC stated issues referred to a half a tablet versus a whole tablet, to ensure accuracy in disposal. The PC stated it was important to ensure controlled medications were not missing. The PC stated, Yes, there is a potential for drug diversion and that is why there are two people during the medication destruction process. A review of the facility's policy titled, Disposal /Destruction of Expired or Discontinued Medication indicated the facility staff should destroy and dispose of mediation in accordance with facility policy and applicable law, and applicable environment regulations. The policy indicated the facility should destroy Schedule II-IV controlled substances as detailed above ., with the following exceptions: Facility should destroy controlled substances in the presence of a registered nurse and a licensed profession. The policy indicated destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional who should record quantity destroyed, date of destruction, and signature of registered nurse and licensed professional. b. A review of Resident 45's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an observation on [DATE] at 2:46 p.m., of medication cart (MedCart) 2, on Nursing Station 2, with Licensed Vocational Nurses (LVN 8), controlled medication administration discrepancies were identified between CDR and the Medication Administration Record ((MAR) a report that serves as a legal record of the drugs administered to a resident at a facility by a health care professional) for Resident 45's controlled medication, [MEDICATION NAME] (a medication that contained [MEDICATION NAME] (an opioid pain reliever) and [MEDICATION NAME] (a non-opioid pain reliever)) 10 milligrams (mg)/ 325 mg as followed: Resident 45's CDR documentation indicated the resident was administered one tablet of [MEDICATION NAME] ,[DATE]mg on [DATE] at 9:42 p.m. However, review of Resident 45's MAR dated [DATE] was empty and did not confirm by documentation the administration of [MEDICATION NAME] to the resident. During a concurrent interview and record review on [DATE], at 3:08 p.m., with LVN 8, Resident 45's MAR, dated [DATE] with the corresponding CDR were reviewed. LVN 8 stated Resident 45's MAR should match with the CDR and confirmed the records did not match. LVN 8 stated she documented Resident 45's [MEDICATION NAME] administration on the CDR on [DATE] at 9 a.m., and confirmed she did not document the [MEDICATION NAME] administration on the resident's MAR on [DATE]. During a concurrent interview and record review, on [DATE], at 4:01 p.m., with the Director of Nursing (DON) stated he could not explain why Resident 45 had two different orders for [MEDICATION NAME] ,[DATE] mg available in the medication cart. The DON reviewed Resident 45's admission records and stated the resident was last discharged from the facility on [DATE] and readmitted on [DATE] and the CDR and medication on discharge should have been removed from the medication cart and given to him. A review of Resident 45's current physician order [REDACTED]. A review of Resident 45's previous physician order [REDACTED]. During a concurrent interview and record review, on [DATE], at 4:25 p.m., with the Medical Records Director (MRD) and DON, Resident 45's CDRs was reviewed between [DATE] through [DATE] indicated, [MEDICATION NAME] ,[DATE] mg was documented to have been administered to the resident on the following dates and time: [DATE] at 12 p.m. [DATE] at 6 a.m., and at 2 p.m. [DATE] at 6 a.m. [DATE] at 6 a.m., and 9 a.m. [DATE] at 10:30 a.m. [DATE] at 9 a.m. [DATE] at 10 a.m. [DATE] at 8 a.m. [DATE] at 6:30 a.m. [DATE] at 2:30 p.m., and 9 p.m. [DATE] at 9:04 a.m. [DATE] at 9 a.m. [DATE] at 8 a.m. [DATE] at 8 a.m. [DATE] at 9:42 p.m. During a concurrent interview and record review, on [DATE], at 4:25 p.m., with the Medical Records Director (MRD) and DON, Resident 45's MARs was reviewed between [DATE] through [DATE] indicated, [MEDICATION NAME] ,[DATE] mg was documented to have been administered by evidence of licensed nurse's signatures or initials on the following dates and time: [DATE] at 10:52 a.m. [DATE] at 10:36 a.m. [DATE] at 8:28 a.m. ,[DATE] at 7:24 a.m. [DATE] at 2:30 p.m., and 8:43 p.m. [DATE] at 9:04 p.m. [DATE] at 8:16 a.m., and 2:30 p.m. [DATE] at 9:41 p.m. on [DATE], at 4:25 p.m., during a concurrent interview with MRD and the DON, the DON counted the number of doses documented to have been administered to Resident 45 between [DATE] through [DATE] that indicated 18 doses of [MEDICATION NAME] ,[DATE] mg were documented on the resident's CDR to have been administered; and ten doses of [MEDICATION NAME] ,[DATE] mg were documented on the resident's MAR to have been administered to Resident 45. The documentation indicated an eight dose discrepancy in the administration of [MEDICATION NAME] ,[DATE] mg to Resident 45. The DON stated, I do not know why the documentation is not matching. The MAR and the controlled drug records should match. The potential is for drug diversion because the nurses are not signing the MAR. The DON stated Resident 45's pain may not be well controlled or the resident may receive duplicate therapy. During a review of the facility's policy and procedure (P&P) titled, Administration of Medications, dated ,[DATE], the P&P indicated, All medications are administered safely and

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) appropriately per physician order [REDACTED]. Medication administration is the responsibility of the nursing professional. During a review of the facility's P&P titled, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, revision dated ,[DATE], the P&P indicated, Facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed . Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **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 record review the facility failed to ensure one of 16 residents (42) medications brought from home was returned to the resident upon discharge, and medications were not kept in use when expired or not dated when: 1. One of one topical skin medication was removed from circulation when expired. 2. One of one wound gel was removed from circulation when expired. 3. One of one medicated lotion had resident label or date open. 4. One of one wound barrier ointment had a date open. 5. One of one hypodermoclysis (method of infusing fluid into the subcutaneous (beneath the layers of the skin) kit was removed from circulation when expired. 6. One of one [MED] (hormone) vial had an open date and was removed from circulation once resident discharged from facility. These deficient practices potentially caused; a) the facility using an expired topical medication and had the potential for ineffective medication treatment, continued symptoms, and delay in care. b) Had the potential for use of lotions and creams past recommended manufacturer guidelines, c) Had the potential of increased harm to residents in using expired subcutaneous supplies, due to inability to ensure sterility (free from contamination) d) Had the potential of accidental use of expired [MED] with increased risk of inefficacy (failure to produce desired effect), and most important, potential for increased risk of infection if used on multiple residents. Findings: a. During an accompanied inspection of the Treatment Cart on [DATE] at 3:48 p.m., the following were identified: 1. One tube of [MEDICATION NAME] ([MEDICAL CONDITION]) Ointment with expiration date of ,[DATE] 2. One [MEDICATION NAME] Gel (wound care dressing) with expiration date of ,[DATE] 3. One bottle of Ammonium [MEDICATION NAME] (topical cream) 12% without resident label and no date open. 4. One tube of [MEDICATION NAME] ointment (skin protectant) without date open. A concurrent interview with Licensed Vocational Nurse (LVN 5) stated if expired, there was a chance the medication and/or ointment would not be effective any longer. LVN 5 stated the ammonium [MEDICATION NAME] 12% was for one resident then when asked if prescribed to one resident would there be a label, then LVN 5 stated it was used for multiple residents. LVN 5 stated she would call the manufacturer or pharmacist for questions regarding expiration. Concurrently, the Director of Nursing (DON) stated there was no open date and in-servicing would have to be done. The DON stated the [MEDICATION NAME] Ammonium had been discontinued for Resident 42. b. During an accompanied inspection of the Intravenous Therapy Cart on [DATE] at 4:13 p.m., the following was identified; 5. One Hypodermoclysis kit with expiration date of [DATE] on [DATE] at 3:48 p.m., during a concurrent interview with Registered Nurse (RN 1) stated expired items should not be used as they may no longer be sterile. RN 1 stated punctured and open items should be disposed due to increased risk of contamination. c. During an accompanied inspection of the Medication Storage Room on [DATE] at 2:02 p.m., the following was identified; 6. One vial of [MEDICATION NAME] N [MED] was without date open for a resident who had been discharged home. on [DATE] at 3:48 p.m., an interview with LVN 6 stated the resident brought the medication and it should have been sent home with the resident when discharged . When asked why the medication was still in the medication storage room refrigerator, DON stated, It should not be there. DON stated there was no [MED] policy. A review of the Admission Face Sheet indicated Resident 42 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Physician order [REDACTED]. A review of Discharge order dated [DATE] indicated Resident 42 was discharged to home on [DATE]. A review of the Progress Notes dated [DATE] indicated Resident 42 was discharged home on the same day at 11:20 a.m. A review of the facility's policy titled, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, indicated the policy set for the procedures related to the storage and expiration dates of medications, biologicals, syringes and needles. The policy indicated the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. The policy indicated facility staff may record the calculated expiration date based on date opened on the medication container. The policy indicated the facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from sue, until destroyed or returned to provide. A review of the facility's policy titled, Medications Brought to Nursing Care Center by Resident or Responsible Party, indicated medications brought into the nursing care center by a resident of responsible party are accepted only with a current order, after the contents are verified by the nurse and packaging meets state, federal and pharmacy guidelines.
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide dental services and follow facility's policy for dental evaluations for one of 1 resident (3). This deficient practice resulted in difficulty in biting food and had the potential to result in lack of dignity, aspiration (food breathed into airways) and malnutrition (lack of sufficient nutrients in the body) for Resident 3. Findings: A review of the Admission Records indicated Resident 3 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Minimum Data Set (MDS), a standardized assessment and care screening tool dated 2/25/20, indicated Resident 3 had no cognitive (ability to learn, reason, remember, understand and make decisions) impairment with daily decision making, and required extensive, one person physical assist for eating. On [DATE] at 9:09 a.m., during an observation and interview, Resident 3 was edentulous (lacking teeth). The resident stated she had lost her dentures and had requested assistance to obtain new dentures from Social Service Designee (SSD) a long time ago. Resident 3 stated she was told SSD would look into the issue of lost dentures. The resident stated she had a difficult time biting her food and was on a regular diet because of not having teeth. On 3/12/20 at 11:54 a.m., during an interview and concurrent record review, SSD stated Resident 3 did not have upper and lower teeth nor dentures and should have been referred to the dentist. A review of the Dental Progress notes indicated Resident 3 was seen on 11/[DATE]9. However SSD stated there were no other documentation found regarding Resident 3 being seen for dental care. On 3/12/20 at 1:50 p.m., during interview SSD contacted dental office and spoke with Office Manager (OM 1). OM 1 stated Resident 3 was seen once on 11/[DATE]9 for complaints of jaw pain but not for problems with not having dentures. OM 1 stated the resident was referred to the ear nose and throat doctor. SSD stated dentures were important for dignity and to enable the resident to eat well. SSD stated she would refer the resident for dentures. A review of the facility's policy and procedure titled, Dental Services last reviewed on [DATE]5/19, it indicated the facility would assist the residents with making appointments and a referral should be done within three days if dentures are lost or damaged.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the alternate menu as written for two of 2 residents (41 and 51) who did not want or could not have dairy/cheese. This deficient practice had the potential to lead to Residents 41 and 51 not meeting their nutritional needs. Findings: On 3/11/20 at 12:30 p.m., during an observation, interview and concurrent record review, Resident 41 who was on a regular, mechanically soft diet was plated ground beef and Resident 51 who was on a consistent carbohydrate regular diet was plated Salisbury steak which were not listen on the menu. Cook stated Residents 41 and 51 could not or did not want cheese therefore could not receive the enchilada. Cook stated Menu #7 for Week 3, Day 4 was being followed for the day and the alternate dish should have been fish. Cook stated the substitute or alternate menu was not used because the resident's did not like fish. However, on 3/11/20 at 1:07 p.m. and 3/11/20 at 1:13 p.m., during interview Residents 51 and 41 stated they liked eating fish. On 3/12/20 at 10:10 a.m., during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055758	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH WALK VILLA CONVAL. HOSP.	12350 ROSECRANS NORWALK, CA 90650

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 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) an interview, Registered Dietician (RD) stated if residents are not able to have cheese, the facility should go by the alternate menu. RD stated the menus are planned ahead and it was important to follow to ensure the residents were receiving a variety of foods [MEDICATION NAME] protein and nutrition. A review of the facility's policy and procedure titled, Menus last revised on 11/28/17 indicated menus are planned in advance and are followed as written in order to meet the nutritional needs of the residents in accordance with established national guidelines.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to ensure the foods were stored and prepared in a sanitary manner for two of 16 residents (48, 210) and other residents who were served from the kitchen by: Failing to monitor and document temperature for 3 refrigerators and 2 freezers in the kitchen. Failing to ensure Residents 48, and 210 did not receive or consume ice from an ice machine that had dark brown and black particles. Staff failing to wash hands prior to going back to the trayline after picking up tongs that fell to the floor. These deficient practices had the potential to result in pathogen (germ) exposure and residents to develop foodborne illness (food poisoning resulting from contaminated food, bacteria, viruses and toxins with symptoms including stomach pain, nausea, vomiting and fever) which could lead to serious medical complications, and hospitalization . Findings: a. On [DATE] at 7:40 a.m., during the initial kitchen tour and interview, temperature logs were not completed for refrigerator 1 and 2 on the following days: [DATE] and 3/7/20 am shifts, freezer 1 on [DATE], 3/3/20, 3/6/20, and 3/7/20 am shifts, freezer 2 on [DATE], 3/3/20 and 3/7/20 am shifts and freezer 3 on [DATE], 3/3/20, 3/7/20 am shifts and on 3/4/20, 3/5/20 and [DATE] pm shifts. During interview the Cook stated temperature checks for the refrigerator and freezers should be checked and logged twice daily. Cook stated it was important to check the temperatures to ensure freezers and refrigerators are kept in proper temperatures for food safety. b. On [DATE] at 7:40 a.m., ice machine was checked using a cloth provided by Cook. There was dark brown and black particles and dirt material obtained from ice machine lid, inside rim and inside crevices above the ice cubes. Cook stated she was not sure when it was not cleaned and did not know where the cleaning log was kept. Cook stated it was the only ice machine in the facility and the protocol would be to discard the ice and clean the ice machine when found to be dirty. On [DATE] at 10:15 a.m., during an observation, interview and concurrent record review, ice from the ice machine had not been discarded. Cleaning schedule log indicated the ice machine was last cleaned on 3/3/20. Dietary Supervisor (DS) stated policy was to clean the ice machine on a weekly basis. DS stated she was aware the ice machine was found to be dirty. DS stated the dirty ice machine could cause bacteria to contaminate the ice and ice will be discarded. DS stated ice had not been distributed and that no residents received the ice from the dirty ice machine. DS stated that ice was not used for drinks at lunch and can purchase ice if it was requested. On [DATE] at 10:39 a.m., during an observation and interview, ice was noted in a pitcher of fruit punch on medication cart 2. Licensed Vocational Nurse (LVN 8) stated ice was filled by 11-7 shift and obtained from the kitchen. LVN 8 stated fruit punch were given to Resident 48, and 210. c. On 3/11/20 at 12:30 p.m., during trayline observation and interview, Cook picked up tongs that fell from the stove to the floor, placed it in the sink and proceeded to continue the trayline without washing hands. Cook was plating the food and handling insulated base for plates and distal part of the handles when scooping food. DS stated Cook should have washed the hands prior to going back to trayline after picking up the tongs from the floor. DS stated that would be an issue with cross contamination and possibility of transferring germs onto the food making it unsafe to eat. A review of an undated facility's policy and procedure titled, Record of Refrigeration Temperatures indicated daily temperatures should be kept of refrigerated items and freezer temperatures must be 0 degrees or less and refrigerator temperatures must be 41 degrees or less. A review of the facility's policy and procedure titled, Trayline Setup and Service last revised on 7/2/18, indicated hands should be washed before working on trayline.
F 0880 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility failed to properly handle clean blankets to prevent contamination, by not picking up a blanket from ground, placing it back on the shelf, and stack additional clean blankets on top of it. The deficient practice had the potential of increased risk in the spread of bacteria to the residents. Findings: During an observation and interview in the laundry room on 3/11/20 at 3:14 p.m., a red blanket was on the floor and Housekeeper (HK 1) picked up the blanket, placed it on the emergency linen only shelf, and proceeded to place two more clean blankets on top of it. A concurrent interview, HK 1 stated, I shouldn't have done that, it is an infection control issue. HK 1 stated she should have placed it to be sent out to wash. Concurrently, HK 2 stated it was not okay to put a blanket on the shelf that been on the ground, it was an infection control issue, it would be contaminated, and should be sent out to be rewashed. A review of the facility's policy titled, 'Laundry Services-General Policy, indicated laundry services are provided in a manner which ensures that a clean supply of linen is on hand. The policy indicated associate will follow infection prevention and control guidelines as outlined in the Infection Prevention and Control Manual.
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an interview and record review the facility failed to administer influenza ((flu) a common [MEDICAL CONDITION] infection that can be deadly, especially in high-risk groups) and pneumonia vaccine (a biological preparation that provides active acquired immunity to a particular infectious disease) to an eligible resident for one of 5 residents (211). This deficient practice placed Resident 211 at a higher risk of acquiring and transmitting the flu and pneumonia (lung infection) from and to other residents, staff, and visitors. Findings: On 3/13/20 at 1:44 p.m., during an interview and concurrent record review, Licensed Vocational Nurse (LVN 6) stated Resident 211 was admitted on [DATE], and had the capacity to make decisions. LVN 6 stated there were no documentation to indicate Resident 211 was offered or administered the pneumonia and flu vaccine which should have been done within 48 hours. On 3/13/20 at 2:04 p.m., during an interview, Registered Nurse 2 stated it was important to offer the flu and pneumonia vaccine to prevent acquiring and spreading the illnesses or limit the severity of illness. A review of the facility's policy and procedure titled, Influenza Vaccine, Pneumococcal Vaccine and Flu Outbreak Management indicated the pneumonia vaccine should be offered to residents [AGE] years of age or older who have not received it or if his/her prior vaccination status is unknown.
F 0912 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide 80 square feet of space per resident in multiple resident bedrooms. This failure to provide adequate space had the possibility for negatively affecting the resident quality of life, safety and plan of care. Findings: On [DATE] at 8:51 a.m., during the entrance conference with the Director of Nursing (DON), it was disclosed the facility had rooms that measured less than 80 square feet per resident in multiple resident bedrooms. During an interview on [DATE] at 1:28 p.m., the DON stated the facility had a room waiver and provided a letter dated 6/[DATE]9 indicating a waiver request for the following rooms: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24,25, 26, 27, 28, 29, 30, 31, 32 and 33 had less than 80 square feet in multi-patient room. A review of the Client Accommodation Analysis form dated 3/11/20 completed and signed by the facility Administrator indicated the following rooms: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, and 32. Resident rooms measured 143.75 square feet (sq. ft.). However, the required room size for two residents in 160 square feet. In addition, Resident room [ROOM NUMBER] measured 230 sq. ft., and required room size for three resident living in the room was 240 sq. ft. During an interview on [DATE] at 10:36 a.m. Resident 19 stated the room was fine and he was able to move around the room fine. During an observation from [DATE] through 3/13/20, the residents' quality of life, care needs, and safety were not adversely affected by the room size. During an observation from [DATE] through 3/13/20, the residents' quality of life, care needs, and safety were not adversely affected by the room size.