STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555822	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON OAKS NURSING AND REHABILITATION CENTER	22029 SATICOY STREET CANOGA PARK, CA 91303

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

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F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to rightfully inform in advance of the risks and benefits of the proposed plan in treatment and services for two of two residents (Resident 437 and Resident 12), reviewed for informed consent. 1. Resident 437's responsible party was not informed of the resident's significant weight changes. This deficient practice had the potential for the resident and responsible party to miss the opportunities to decide whether to proceed the treatments fraom developing increased risks for impaired nutrition status. 2. Resident 12 was not provided informed consent (permission granted by a resident or resident representative to proceed with treatment after the physician had fully explained the benefits and possible risks or consequences) for the increased dosage of [MEDICATION NAME] (a [MEDICAL CONDITION] medication (any medication capable of affecting the mind, emotions, and behavior) (used to treat [MEDICAL CONDITION] disorder- a severe mental disorder that causes periods of depression and abnormally elevated moods). This deficient practice resulted in Resident 12 continuing to use [MEDICATION NAME] without knowing the risks and benefits of the increased dosage of the medication. This also had the potential to place the resident and resident representative at risk for missing the opportunity to decide whether to proceed or to refuse the treatment. Findings: a. A review of Resident 437's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 437's Transfer/Discharge Report indicated Resident 437 was discharged to an assisted living facility on 01/28/2020 at 9:00 a.m. During a review of Resident 437's Skilled Nursing Home History and Physical Exam (SNHH&PE), dated 12/03/2019, the SNHH&PE indicated, Resident 437 had fluctuating capacity to understand and make decisions. A review of Resident 437's Minimum Data Set (MDS - a standardized assessment and screening tool) dated on 12/12/2019, indicated Resident 437's cognition (thought process) for daily decision making was intact. The MDS also indicated Resident 437 needed extensive assistance from staff for bed mobility, transfer, dressing, toilet use, personal hygiene, bathing, and limited assistance for eating. During a review of Resident 437's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 12/12/2019, the admission assessment indicated Resident 437's weight was 124 pounds. The MDS dated [DATE], the discharge assessment, indicated Resident 437's weight was 102 pounds. During an interview on 03/02/2020, at 09:05 a.m., the resident representative (RR) stated he/she was not informed about Resident 437's malnutrition status with significant weight loss. During a concurrent interview, and record review, on 03/05/2020 at 9:46 a.m., with the Assistant Director of Nursing (ADON), stated staff did not report to Resident 437's representative the resident's weight of 111 pounds on [DATE], (a loss of 13 pounds since admission), the resident's weight of 109 pounds on 01/14/2020 (a loss of 15 pounds since admission), and the resident's weight of 105 pounds on 0[DATE], (a total loss of 19 pounds since admission). During an interview on 03/06/2020, at 11:03 a.m., with the Director of Nursing (DON), the DON stated, the resident had been losing weight significantly while staying in the facility, the staff should notify the resident's representative for the changes of condition and update the resident's nutritional status. A review of the facility's undated Policy and Procedure titled Change in Condition indicated It is the policy of this facility that changes in resident condition be communicated to the resident and/or responsible party/family and the physician. Examples of changes in resident condition: significant weight gain or loss. Document notification of resident and/or responsible party/family and physician. A review of the facility's policy and procedure (P&P) titled, Weight management, dated June 2016, indicated, The criteria for a resident to be reviewed may include, but is not limited to: a. Resident who have a sudden change in nutritional intake and are at risk for significant weight loss or exhibit gradual weight loss/gain. g. Resident with progressive weight loss requiring close observation. b. A review of Resident 12's Face Sheet (admission record) indicated the resident was initially admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 12's History and Physical (H&P), dated 7/6/19, indicated the resident had the capacity to understand and make decisions. A review of Resident 12's Minimum Data Set (MDS - a residents' assessment and screening tool) dated 12/22/19, indicated the resident had severe impairment in cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required extensive physical assistance for bed mobility, transfer, dressing, personal hygiene, required limited assistance for eating and is totally dependent on staff for toileting. A review of the Resident 12's Physician and Telephone Orders, dated 5/7/19, indicated to discontinue [MEDICATION NAME] 12.5 mg (milligrams- unit of measure), and to start with [MEDICATION NAME] 25 mg by mouth at bed time for [MEDICAL CONDITION] manifested by sudden yelling/screaming at the staff and roommate. During an interview, on 3/5/20 at 4:21 P.M., the Assistant Director of Nursing (ADON) stated the only record for physician informed consent obtained was from 2/12/18. The ADON validated that when the dosage for [MEDICATION NAME] increased on 5/7/19, the physician should have obtained an informed consent prior to the administration of the medication. The ADON acknowledged that the resident and/or responsible party should have been informed of the risks and benefits of the increase in medication and for the resident and/or responsible party to have the opportunity of refusing the medication. A review of the facility's Policy and Procedures (P&P), titled Informed Consent, review date of [DATE]19, indicated: 1. It is the responsibility of the prescribing physician, to obtain consent, whereby applicable and indicated by state & federal regulations, from resident or a representative of an incapacitated resident for administration of treatment and/or procedures. 2. For use of physical restraints and psychotherapeutic medications, licensed personnel shall verify the presence of an informed consent signed by the prescribing physician in the resident's medical record, prior to use. 3. The nurse receiving the order will not administer the restraint or psychotherapeutic medication until verification of informed consent signed by the prescribing physician is documented in the resident's medical record.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accommodate the needs for one of one resident (Resident 536), investigated under the environment task, by failing to ensure the call light was answered promptly. This deficient practice had the potential to result in a delay in the provision of necessary care and services for Resident 536. Findings: A review of Resident 536's Face Sheet (admission record) indicated the resident was initially admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 536's Minimum Data Set (MDS - a residents' assessment and screening tool) dated 2/19/20, indicated the resident had no impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required extensive physical assistance for bed mobility, transfer, dressing, personal hygiene, and toilet use, and required supervision for eating. During an interview, on 3/5/20 at 10:24 A.M., Resident 536 stated that before 9 P.M. he pressed

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

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

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) his call light to ask for help in using the urinal (a plastic bottle for urination), a CNA came to assist him to pull his pants down and in an upright sitting position, afterwards the CNA told the resident that he will send someone in. Resident 536 stated he had to press his call light again after waiting for 15 minutes when no one came back to helped him as promised by the first CNA. Resident 536 stated that when the Licensed Vocational Nurse (LVN) nurse came to answer his call light and give his evening medication, the LVN told the resident that the CNAs were on break and that she will send somebody to help him get to bed. Resident 536 verified he waited for another 10 minutes before finally getting assisted to bed. Resident 536 stated he was not able to recall who the CNA and the LVN was, who came to assist him. During an interview, on 3/5/20 at 10:52 A.M., the Director of Staff Development (DSD) stated that call lights should be answered by all staff immediately. The DSD also verified that any CNA and even the charge nurses should assist the resident with toileting and getting to bed. During an interview, on 3/5/20 at 2:54 P.M., Certified Nurse Aide 5 (CNA 5) stated that she answers call lights immediately. CNA 5 acknowledged that when she is assigned to cover for another CNA, who is on a lunch break she will assist the resident to use his urinal and to go to the bed, rather than calling to send someone else to assist. A review of the facility's Policy and Procedures titled Call Lights, with a review date of 3/20/19, indicated the staff should answer the resident's call light as soon as possible and as safe if staff are working with another resident at the time of the light.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to update and or revise a resident's comprehensive care plan after the physician changed the antidepressant medication (medication for the treatment of [REDACTED]. This deficient practice had the potential to result in lack of adequate monitoring and documentation of specific targeted behavior for Resident 39's use of [MED] (antidepressant medication). Findings: A review of Resident 39's admission record (face sheet) indicated the resident was admitted to the facility from a general acute care hospital (GACH) on 12/17/2019, with [DIAGNOSES REDACTED]. A review of Resident 39's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 1[DATE]19, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated that the resident was receiving an antidepressant medication during the look back period (time frame for observation). A review of the Physician and Telephone Orders form dated 0[DATE]20, indicated an order to discontinue [MEDICATION NAME] (a medication used to treat depression). The form indicated an order for [REDACTED]. The care plan was not updated and or revised after the physician changed the resident's antidepressant medication to [MED] on 02/2/4/2020. On 03/03/2020 at 10:33 AM, during an interview with Registered Nurse 4 (RN 4), she stated that Resident 39's care plan should have been updated after the medication change. A review of the facility policy and procedure titled, Care Plans, with a revised date on 10/2017, indicated that assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.
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 interview and record review, the facility failed to meet professional standards of quality care for three of 3 residents (Resident 115, 120, and 83), reviewed for the care area of professional standards by failing to: 1. Ensure Resident 115 was not administered a medication he was allergic to. This deficient practice had the potential to place Resident 115 at risk for an allergic reaction (an exaggerated reaction by the immune system in response to exposure to certain foreign substances) that may lead to an adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have). 2. Measure Resident 120's orthostatic blood pressure to detect orthostatic [MEDICAL CONDITION] (a decrease in systolic blood pressure -the amount of pressure in arteries during the contraction of the heart or a decrease in diastolic blood pressure -when the heart is in a period of relaxation, within three minutes of standing compared with blood pressure from a sitting or a lying position) weekly to make sure the resident did not have side effects from [MEDICAL CONDITION] medications (any medication capable of affecting the mind, emotions, and behavior), including: [MEDICATION NAME] used to treat nervousness, [MEDICATION NAME] HCL Extended Release used to treat depression, [MEDICATION NAME] Oxalate used to treat depression, [MEDICATION NAME] used to treat [MEDICAL CONDITION], and Quetiapine [MEDICATION NAME] tablet 100 mg, used to treat [MEDICAL CONDITION] disorder. This deficient practice had the potential to place Resident 120 at risk for complications of medications including dizziness and light-headedness that can lead to falls/injuries. 3. Ensure that Resident 83 received medications as ordered by the physician including pain medication, and medication to treat dementia, [MEDICAL CONDITION] and depression. This deficient practice had the potential to result in ineffective management of pain, dementia (a persistent disorder of the mental processes), [MEDICAL CONDITION] (convulsions) and depression for Resident 83. Findings: a. A review of Resident 115's Face Sheet (admission record) indicated the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 115's History and Physical (H&P), dated 2/4/20, indicated the resident is allergic (an exaggerated reaction by the immune system in response to exposure to certain foreign substances) to Aspirin (ASA- medication used to reduce pain, fever or inflammation). A review of Resident 115's Minimum Data Set (MDS - a resident assessment and screening tool) dated 2/9/20, indicated the resident had moderate impairment in cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required extensive physical assistance from staff for bed mobility, transfer, dressing, personal hygiene, eating and toileting. A review of Resident 115's GACH (General Acute Care Hospital) Skilled Nursing Facility Transfer Orders (SNFTO) dated 2/3/20, indicated the resident is allergic to Aspirin. A review of Resident 115's Physician and Telephone Orders, dated and signed by the physician on 2/3/20, indicated that resident is to receive Aspirin 81 mg (Milligrams -unit of measure) by mouth daily. A review of Resident 115's Medication Administration Record (MAR), dated 2/25/20 to 2/29/20, indicated that the resident was given Aspirin 81 mg by mouth daily. A review of Resident 115's MAR, dated 3/1/20 to 3/4/20, indicated that the resident was given Aspirin 81 mg by mouth daily. During an interview, on 3/3/20 at 11:15 A.M., the Director of Nursing (DON) stated that the Aspirin was being given to the resident because it was an order from the physician to administer the medication. The DON acknowledged that it is the licensed nurse's responsibility to advocate for the resident by verifying the allergies [REDACTED]. The DON verified that she will reach out to call the family member of Resident 115 to verify how the resident displays an allergic reaction to the Aspirin and communicate with the physician. A review of the facility's Policy and Procedures (P&P), titled Medication and Treatment Orders, with review date 3/20/20, indicated that allergies [REDACTED]. If prescriber chooses to continue the order, an explanation in the progress notes should be noted. Monitoring procedures should be implemented to prevent any adverse reactions. b. A review of the Admission Record indicated Resident 120 was admitted to the facility on (NAME)30, 2018, and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 120's Minimum Data Set (MDS- a standardized resident assessment and care screening tool) dated February 12, 2020, indicated the resident's speech is clear and is able to make herself understood and understand others. The MDS indicates the resident requires extensive assistance with bed mobility (turning side to side and positioning while in bed), transfer, locomotion off and on unit, dressing, toilet use, and personal hygiene. On (NAME)5, 2020, at 11:30 a.m., during a concurrent record review, and interview, regarding Resident 120's medication administration record (MAR), the Assistant Director of Nursing (ADON) stated, the licensed nurses measure orthostatic BP weekly for those residents who are taking [MEDICAL CONDITION] medications. The ADON could not tell why there is only one number recorded on the MAR for the orthostatic BP, which appeared to be the systolic BP. The MAR did not indicate complete orthostatic BP entries. The ADON stated she could not tell why there is no BP value recorded on the MAR to indicate the resident's BP was taken in different positions (sitting to standing or lying to standing) to find out if the resident's BP drops when the resident changes her position. A review of Resident 120's physician's orders [REDACTED]. [MEDICATION NAME] 0.5 mg one tablet by mouth Monday, Wednesday, Friday for nervousness, dated 5/10/2019. 2. [MEDICATION NAME] HCL Extended Release tablet every 12 hours 150 mg one tablet every day for depression, dated 5/10/2019. 3. [MEDICATION NAME] Oxalate tablet 20 mg one tablet by mouth every day for depression, dated 1/30/2020. 4. [MEDICATION NAME] 2mg/ML, give 1.5 mg by mouth twice a day for [MEDICAL CONDITION], dated 5/10/2019, and renewed 2/7/2020 5. Quetiapine [MEDICATION NAME] tablet 100 mg, one tablet by mouth at bedtime related to [MEDICAL CONDITION] disorder, dated 5/10/2019. A

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) review of Resident 120's MAR from 12/2019 to 3/6/2020, indicated the licensed nurses have not been entering orthopedic BP correctly. On (NAME)6, 2020, at 8:50 a.m., during an interview, the ADON stated, she does not know what happened and why there was no accurate blood pressure measurements recorded in MAR. ADON was not able to find any other documented evidence to show orthopedic BP. c.1. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) administered Regular Strength [MEDICATION NAME] (Tylenol, a medication indicated for the treatment of [REDACTED]. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order, dated 1/31/20, for Tylenol ([MEDICATION NAME]) 8 Hour Tablet Extended Release (ER formulation, releases drug slowly over time for fewer side effects) 650 mg, Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain, pain scale 1-4/10 (pain score one to four out of ten, on a pain rating scale of zero to ten, zero being no pain and ten being the worst possible pain), DNE 3g/day (do not exceed 3 grams per day). A review of Resident 83's Admission Record (face sheet), dated 2/5/20, indicated a [DIAGNOSES REDACTED]. During an interview, on 3/3/20 at 10:21 a.m., the licensed vocational nurse (LVN 13), regarding administering Regular Strength [MEDICATION NAME] to Resident 83 during med pass, when the electronic medication administration record (MAR) indicated to give Extended Release Tylenol, acknowledged the discrepancy and stated, Oh yes. A review of the facility's pharmacy policy and procedures, titled, Administering Medications, effective date (NAME)2016, indicated, Medications must be administered in accordance with the orders. The licensed nurse must check the label three (3) times to verify the right dose before giving the medication. c.2. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] (Donezepil, a medication used to treat mild to moderate dementia) 10 mg (strength in milligrams) by mouth. The Donezepil was identified, upon verification of the medication orders, after the med pass was conducted. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. A review of Resident 83's Admission Record (face sheet), dated 2/5/20, indicated a [DIAGNOSES REDACTED]. During an interview, on 3/3/20 at 10:27 a.m., LVN 13, regarding the [MEDICATION NAME], stated, I probably did not give you the (medication) card (to copy the label), because I was waiting for the refill. c.3. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] (levetiracetam, a medication used to treat [MEDICAL CONDITION]) 1,000 mg by mouth. The [MEDICATION NAME] was identified, after the med pass, upon verification of the medication orders. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. A review of Resident 83's Admission Record (face sheet), dated 2/5/20, indicated a [DIAGNOSES REDACTED]. During an interview, on 3/3/20 at 10:29 a.m., LVN 13, regarding the [MEDICATION NAME], stated, I'm sorry, I did not give it to her. c.4. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] ([MEDICATION NAME], a medication used to treat depression, obsessive-compulsive disorder- a mental disorder, and panic disorder- a mental disorder) Capsule 20 mg (strength in milligrams), which was identified after the med pass, upon verification of the medication orders. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. A review of Resident 83's Admission Record (face sheet), dated 2/5/20, indicated a [DIAGNOSES REDACTED]. During an interview, on 3/3/20 at 10:33 a.m., LVN 13, regarding the [MEDICATION NAME], acknowledged that she did not administer the [MEDICATION NAME], and stated, I am waiting for the refill, sir. A review of the facility's pharmacy policy and procedures, titled, Administering Medications, effective date (NAME)2016, indicated, Definition, Medications must be administered in accordance with orders. The licensed nurse must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The expiration date on the medication label must be checked prior to administering.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards for two of two residents (Resident 14 and 485), reviewed under the care area of respiratory care by: 1. Failing to ensure infection control measures were taken in handling and storage of a resident's nebulizer machine (respiratory breathing treatment equipment that makes a mist for inhalation of medication), for Resident 14. 2. Failing to ensure Resident 485 received oxygen therapy as ordered by the physician. These deficient practices placed Resident 14 at risk for using an equipment that is contaminated, and can lead to infections/illnesses and placed Resident 485 at risk of not receiving enough oxygen and becoming short of breath. Findings: a. A review of Resident 14's admission record (face sheet) indicated the resident was initially admitted to the facility on [DATE], from a general acute care hospital (GACH), and most recently readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 14's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 11/26/2019, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated the resident was receiving respiratory equipment during the look back period (time frame for observation). A review of Resident 14's Comprehensive Care Plan dated 12/26/2019, indicated the resident has potential for respiratory infection related to [MEDICAL CONDITIONS] and asthma (a condition in which the airways become sore and swollen). The interventions included, emphasizing good handwashing techniques to all direct care staff, [MEDICATION NAME] (a medication used in a mist that is inhaled to relax and open the air passages to make breathing easier), 0.02% (percent) every 4 hours, as needed for wheezing (an abnormal breathing sound) and shortness of breath. A review of the Order Summary Report with active orders as of 03/01/2020, indicated the following orders for Resident 14: 1. [MEDICATION NAME] Nebulization (medication used to treat wheezing and shortness of breath caused by breathing problems) Solution (2.5 milligram/3 milliliters) 0.083 percent, 3 ml (milliliters), inhale orally (by mouth), via nebulizer every 4 hours as needed for shortness of breath or wheezing due to [MEDICAL CONDITION], with an order date of 12/26/2019. 2. [MEDICATION NAME] Solution 0.02 percent, 3 ml inhale orally, every 4 hours as needed for shortness of breath or wheezing, due to [MEDICAL CONDITION] via hand held nebulizer (HHN-a small air compressor that turns medicine into a mist to be inhaled into the lungs). During an observation, and concurrent interview, with Registered Nurse 4 (RN 4) on 03/03/2020 at 09:55 AM, Resident 14's nebulizer machine was observed covered with dust and dried brown spots. There was a roll of trash bags placed on top of the machine. RN 4 stated that the nurses should have kept the machine clean and sanitized. During an interview, with the Director of Nursing (DON) on 03/04/2020 at 12:16 PM, the DON stated that the housekeeping staff is responsible for cleaning and sanitizing the nebulizer machine with germicidal wipes every day for infection control. A review of the facility policy and procedure titled, Cleaning and Disinfection of Resident Care Items and Equipment, dated 01/12/2017, indicated that resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected using Environmental Protection Agency (EPA) guidelines to minimize the risk and spread of infectious agents. Semi-critical items consists of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment. Such devices should be free from all microorganisms. b. On (NAME)2, 2020, at 11:18 a.m., during an initial tour of the facility, Resident 485 was observed sitting in his wheelchair in his room. The oxygen in use sign was posted at the door. The resident was receiving oxygen at two liters of oxygen per minute via nasal cannula (a thin tube that has two prongs and is connected to the oxygen concentrator and placed in the nose) which was connected to a portable oxygen tank. The resident seemed irritable by changing his position often and his oxygen tank was empty. Licensed Vocational Nurse 9 (LVN 9) checked the resident's oxygen saturation (the extent to which your blood is saturated with oxygen), and the result was 83 percent (%). (The normal adult reference range is 95 to 100 % on room air). During a concurrent observation, and interview, LVN 9 stated she did not know the oxygen tank was empty. Certified Nursing Assistant 3 (CNA 3) who was assisting the resident, was not aware of the empty oxygen tank either, he stated. LVN 9 stated Resident 485 is supposed to receive oxygen at two liters per minute (2 L/m) continuously. A review of the Physician's Order dated February 25, 2020, indicated to administer oxygen at 2 L/m via nasal cannula every shift. May titrate (continually monitoring and adjusting the amount of) up to 5 L/m to maintain oxygen saturation greater than 94 percent (%). A review of the Admission Record indicated Resident 485 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 485's History and Physical (H & P), dated February 26, 2020, indicated the resident is alert and oriented. A review of the care plan initiated on February 26, 2020, indicated Resident 485 has a

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) potential for altered cardiovascular status. The approaches indicated to assess for shortness of breath and cyanosis. Administer oxygen via nasal cannula at 2 L/m continuous. There was another care plan dated February 26, 2020, indicating the resident has a potential for altered respiratory status/difficulty breathing due to cough, bronchiectasis (a condition in which the lungs' airways become damaged, making it hard to clear mucus), and status [REDACTED]. A review of the facility's policy and procedure dated July 2016, titled, Oxygen Administration, indicated that oxygen therapy is administered upon a physician's order or in the event of an emergency by a licensed nurse or respiratory therapist.
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 interview, and record review, the facility failed to ensure effective pain management by failing to document the pain assessments and non-pharmacological (without medication) interventions for one out of five residents, investigated under the care area of pain management (Resident 120). This deficient practice had the potential to result in lack of detection of unrelieved pain for Resident 120 and also had the potential for the resident to unnecessarily suffer with pain. Findings: A review of the Admission Record indicated Resident 120 was admitted to the facility on (NAME)30, 2018, and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 120's Minimum Data Set (MDS- a standardized resident assessment and care screening tool) dated February 12, 2020, indicated the resident's speech is clear and she is able to make herself understood and understand others. The MDS indicates the resident requires extensive assistance with bed mobility (turning side to side and positioning while in bed), transfer, locomotion off and on unit, dressing, toilet use, and personal hygiene. A review of Resident 120's physician's orders [REDACTED]. On (NAME)6, 2020, at 8:20 a.m., Resident 120 was observed lying in bed. The resident was awake and alert, communicable in a language other than the dominant language used in the facility. When Certified Nursing Assistant 7 (CNA 7), translated, CNA 7 stated the resident said from time to time the resident takes [MEDICATION NAME] for left side flank pain. On (NAME)6, 2020, at 8:30 a.m., during an observation of Medication Cart 4, in Station 4, and a concurrent record review, in the presence of Licensed Vocational Nurse 10 (LVN 10), the removal of Resident 120's [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) from the bubble pack (packaging in which medications are organized and sealed between a cardboard backing and clear plastic cover) and its documentation on the Controlled Medication Count Sheet (accountability record of medications that are considered to have strong potential for abuse) were reviewed. The Controlled Medication Count Sheet indicated a [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) dose was removed on (NAME)1, 2020, at 9:00 p.m., (NAME)2, 2020, at 9:00 a.m. and 5:00 p.m., on (NAME)4, 2020, at 9:00 a.m. and 6:40 p.m. During a concurrent record review and interview with LVN 10, he stated that when any resident complains of pain, he would ask the resident the pain level rating on a scale of one to ten, and the location of pain. LVN 10 stated he offers non-pharmacological intervention first, such as repositioning, emotional support, and deep breathing. LVN 10 stated he then documents with the code numbers on the MAR. LVN 10 stated no one should put zero for non-pharmacological intervention on the MAR, when residents complain of pain. LVN 10 acknowledged that several nurses entered zero in the column of non-pharmacological (interventions other than using medication) interventions. On (NAME)6, 2020 at 10:04 a.m., during an interview with the Registered Nurse 4 (RN 4), and a concurrent review of Resident 120's Medication Administration Records (MARs), RN 4 stated there was no documentation that a dose of [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) was administered on (NAME)1, 2020, at 9 p.m. and (NAME)2, 2019 at 5:00 p.m. RN 4 stated the licensed nurses should have documented on the MAR that the [MEDICATION NAME] dose was given. On (NAME)6, 2020 at 10:04 a.m., during a record review of Resident 120's (NAME)2020, MAR and a concurrent interview, RN 4 stated there was no pain assessment documented when the [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) dose was removed from the bubble pack on (NAME)1, 2019 at 9:00 p.m., (NAME)2, 2020, at 9 a.m. & 5 p.m., and (NAME)4, 2020, at 9 a.m. RN 4 stated the licensed nurses should have documented why the pain medication was given and should have completed a pain assessment each time to see if the pain medication is effective.
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 observations, interviews, and record reviews, the facility failed to provide routine pharmaceutical services (including procedures that assure accurate acquiring, receiving, and administering of all drugs to meet one (1) out of three (3) resident's needs (Resident 83), observed during the morning medication administration) by: 1. Failing to ensure that nursing staff administered the correct formulation of an over-the-counter house supply medication ([MEDICATION NAME]) to Resident 83. This deficient practice had the potential for harm to Resident 83 by receiving a medication formulation not prescribed by the physician. 2. Ensure that the nursing staff did not miss administering three (3) medications, as prescribed, to Resident 83 including pain medication, and medication to treat dementia, [MEDICAL CONDITION] and depression. This deficient practice had the potential for harm to Resident 83 due to not receiving medications indicated for the treatment of [REDACTED]. Findings: 1. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) administered Regular Strength [MEDICATION NAME] (Tylenol, a medication indicated for the treatment of [REDACTED]. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order, dated 1/31/20, for Tylenol ([MEDICATION NAME]) 8 Hour Tablet Extended Release (ER formulation, releases drug slowly over time for fewer side effects) 650 mg, Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain, pain, scale 1-4/10 (pain score of one to four out of ten, on a pain rating scale of zero to ten, zero being no pain and ten being the worst possible pain), DNE 3g/day (do not exceed 3 grams per day). A review of Resident 83's Admission Record (face sheet), dated 2/5/20, indicated a [DIAGNOSES REDACTED]. During an interview, on 3/3/20 at 10:21 a.m., the licensed vocational nurse (LVN 13), regarding administering regular strength [MEDICATION NAME] to Resident 83 during med pass when the electronic Medication Administration Record [REDACTED]. A review of the facility's pharmacy policy and procedures, titled, Administering Medications, effective date (NAME)2016, indicated, Medications must be administered in accordance with the orders. The licensed nurse must check the label three (3) times to verify the right dose before giving the medication. 2a. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] (Donezepil, a medication used to treat mild to moderate dementia) 10 mg (strength in milligrams) by mouth, which was identified upon verification of the medication orders, after the med pass was conducted. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. During an interview, on 3/3/20 at 10:27 a.m., LVN 13, regarding the [MEDICATION NAME], stated, I probably did not give you the (medication) card (to copy the label), because I was waiting for the refill. 2b. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] (levetiracetam, a medication used to treat [MEDICAL CONDITION]) 1,000 mg by mouth, which was identified after the med pass, upon verification of the medication orders. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. During an interview, on 3/3/20 at 10:29 a.m., LVN 13, regarding the [MEDICATION NAME], stated, I'm sorry, I did not give it to her. 2c. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] ([MEDICATION NAME], a medication used to depression, obsessive-compulsive disorder, and panic disorder) Capsule 20 mg, which the surveyor identified after the med pass upon verification of the medication orders. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. During an interview, on 3/3/20 at 10:33 a.m., LVN 13, regarding the [MEDICATION NAME], acknowledged that she did not administer the [MEDICATION NAME] and stated, I am waiting for the refill, sir. A review of the facility's pharmacy policy and procedures, titled, Administering Medications, effective date (NAME)2016, indicated, Definition: Medications must be administered in accordance with orders. The licensed nurse must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The expiration date on the medication label must be checked prior to administering.

F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication;**

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	555822	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON OAKS NURSING AND REHABILITATION CENTER	22029 SATICOY STREET CANOGA PARK, CA 91303

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) **and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that two of two residents (Resident 12 and 120), reviewed for the care area of pharmacy services were free from unnecessary [MEDICAL CONDITION] medications, (any drug capable of affecting mood, emotions, behavior) by: 1. Failing to accurately monitor the behavior for the use of [MEDICATION NAME] (a [MEDICAL CONDITION] medication used to treat [MEDICAL CONDITION] disorder- a severe mental disorder that causes periods of depression and abnormally elevated moods) for Resident 12. 2. Failing to ensure effectiveness of [MEDICATION NAME] due to inaccuracy of the three-months reading documented on the Gradual Dose Reduction Form (GDRF- attempts used to reduce dosage of medications) to indicate the behavior monitored for the use of [MEDICATION NAME] for three months for Resident 12. 3. Failing to attempt GDR for Resident 120 for the use of [MEDICATION NAME], and [MEDICATION NAME] ([MEDICAL CONDITION] medications) These deficient practices had the potential to result in Resident 12 and 120 to experiencing unrecognized adverse side effects related to unnecessary use of antipsychotic medication use including daytime drowsiness, dizziness, blurred vision, restlessness, muscle spasms, confusion and may increase the risk of stroke, falls and injuries, and are associated with higher rates of death in the elderly. Findings: a. A review of Resident 12's Face Sheet (admission record) indicated the resident was initially admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 12's History and Physical (H&P), dated 7/6/19, indicated the resident had the capacity to understand and make decisions. A review of Resident 12's Minimum Data Set (MDS - a residents' assessment and screening tool) dated 12/22/19, indicated the resident had severe impairment in cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required extensive physical assistance for bed mobility, transfer, dressing, personal hygiene, required limited assistance for eating and is totally dependent on staff for toileting. A review of Resident 12's Order Summary Report (OSR), dated 3/1/20, indicated to document number of episodes per shift of target behavior manifested by sudden yelling/screaming at staff and roommate, chart frequency tally by hashmark every shift. A review of Resident 12's Medication Administration Record [REDACTED]. During an interview, on 3/4/20 at 2:30 P.M., the Assistant Director of Nursing (ADON) stated that the MAR indicated [REDACTED]. The ADON acknowledged that the effectiveness of the medication is validated if there was tallying by hashmarks for the behavior on each shift. b. A review of Resident 12's Psych GDR Form dated 1/21/20, indicated that the Summary of Review for three months from were all Zero's. During concurrent interview, on 3/5/20 at 2:25 P.M., the Licensed Vocational Nurse 10 (LVN 10) stated that she was the one who documented all zeros because she assumed that the check marks on the MAR meant zeros and with no behaviors manifested. LVN 10 acknowledged that her basis should have been hash marks tallied and not check marks. A review of the facility's Policy and Procedures (P&P), titled Behavior Monitoring for [MEDICAL CONDITION] Medication, Anti-psychotic, Anti-depressant, Anti-anxiety and Hypnotic, with review date 3/20/2019, indicated to monitor behavior every shift tally by hash marks and number of hours of sleep for hypnotic monitoring. c. A review of the Admission Record indicated Resident 120 was admitted to the facility on (NAME)30, 2018, and readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 120's physician order [REDACTED]. There was another order dated 5/10/19, indicating that the resident was prescribed [MEDICATION NAME] 2 mg/mL, give 1.5 mg by mouth twice a day for [MEDICAL CONDITION]. A review of a Note to Attending Physician/Prescriber dated 1/31/2020, indicated the consulting pharmacist indicated that Resident 120 has been taking [MEDICATION NAME] 100 mg every bedtime and [MEDICATION NAME] 1.5 mg by mouth every day since 5/10/19, and suggested a dose reduction, however, the physician responded GDR is contraindicated, because target symptoms returned, or worsened after a past GDR and it is contraindicated, because any additional GDR would impair the resident's function. There was no documented evidence that GDR was applied in the past. A review of Note to Attending Physician/Prescriber dated 1/31/2020, indicated the consulting pharmacist indicated that the resident has been taking [MEDICATION NAME] 20 mg every day and [MEDICATION NAME] 150 mg by mouth every day for depression since 5/11/19, and suggested a dose reduction, however, the physician responded GDR is contraindicated, because target symptoms returned, or worsened after a past GDR and it is contraindicated, because any additional GDR would impair the resident's function. There was no documented evidence that GDR was applied in the past. A review of [MEDICAL CONDITION] Interdisciplinary Team (IDT) Assessment Gradual Dose Reduction (GDR) dated 6/18/19, for [MEDICATION NAME] for the month of 5/2019, indicated Resident 120's behavior manifested by outburst and crying had no documented evidence. There was another IDT Assessment for GDR dated 8/20/19, for [MEDICATION NAME], for the month of (NAME)2019, and July 2019, indicating the resident did not have any episodes. A review of [MEDICAL CONDITION] IDT Assessment for GDR dated 6/18/19, for [MEDICATION NAME], for the month of 5/2019, indicated Resident 120's behavior manifested by screaming/yelling had no hash marks (episodes). According to another IDT Assessment GDR dated 8/20/19, for [MEDICATION NAME], for the month of (NAME)2019, and July 2019, indicated the resident did not have any episodes. A review of [MEDICAL CONDITION] IDT Assessment GDR dated 6/18/19, for [MEDICATION NAME], for the month of 5/2019, indicated Resident 120's behavior manifested by sad facial expression had no hash marks (episodes). There was another IDT Assessment GDR dated 6/18/19, for [MEDICATION NAME], for the month of May 2019, indicating Resident 120's behavior manifested by verbalization of sadness had no hash marks. At a concurrent record review and interview, the Assistant Director of Nursing (ADON) stated that staff members should have recorded the number of episodes and if there were no behavioral issues, then GDR should have been done. ADON stated that she has not noticed any unusual behaviors of the resident, such as screaming/yelling and outburst and crying. On 3/3/2020 at 10:10 a.m., during an interview, Certified Nurse Assistant 7 (CNA 7) stated that he has provided direct care to Resident 120 at times. CNA 7 stated that he has not had any occasion to observe Resident 120's outburst crying or screaming/yelling at all. A further review of Resident 120's clinical record indicated no additional documentation of a clinical rationale as to why the risks of discontinuing or reducing the dosage of [MEDICATION NAME] and [MEDICATION NAME] outweighed the benefits of continuing it could be found. A review of the facility's policy dated December 2016, titled Antipsychotic Medication Use, indicated the physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. Another policy dated October 2017, titled, [MEDICAL CONDITION] Medication Use, indicated all medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All residents receiving medications used to treat behaviors should be monitored for efficacy, risks, benefits, harm or adverse consequences. Facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving [MEDICAL CONDITION] medication for BPSD. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the medication error rate of less than five (5) percent, due to four (4) medication administration errors involving one (1) resident out of three (3) residents observed during medication administration (med pass). This deficient practice of a medication administration error rate of ten and fifty-three hundredths percent (10.53%) exceeded the five (5) percent threshold. Findings: 1. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) administered Regular Strength [MEDICATION NAME] (Tylenol, a medication indicated for the treatment of [REDACTED]. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order, dated 1/31/20, for Tylenol ([MEDICATION NAME]) 8 Hour Tablet Extended Release (ER formulation, releases drug slowly over time for fewer side effects) 650 mg, Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain, pain scale 1-4/10 (pain score one to four out of ten), DNE 3g/day (do not exceed 3 grams per day). A review of Resident 83's Admission Record (face sheet), dated 2/5/20, indicated a [DIAGNOSES REDACTED]. During an interview, on 3/3/20 at 10:21 a.m., the licensed vocational nurse (LVN 13), regarding administering regular strength [MEDICATION NAME] to Resident 83 during med pass when the electronic Medication Administration Record [REDACTED]. A review of the facility's pharmacy policy and procedures, titled, Administering Medications, effective date (NAME)2016, indicated, Medications must be

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) administered in accordance with the orders. The licensed nurse must check the label three (3) times to verify the right dose before giving the medication. 2a. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] (Donezepil, a medication used to treat mild to moderate dementia) 10 mg (strength in milligrams) by mouth, which the surveyor identified upon verification of the medication orders after the med pass was conducted. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. During an interview, on 3/3/20 at 10:27 a.m., LVN 13, regarding the [MEDICATION NAME], stated, I probably did not give you the (medication) card (to copy the label), because I was waiting for the refill. 2b. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] (levetiracetam, a medication used to treat [MEDICAL CONDITION]) 1,000 mg by mouth, which the surveyor identified after the med pass upon verification of the medication orders. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. During an interview, on 3/3/20 at 10:29 a.m., LVN 13, regarding the [MEDICATION NAME], stated, I'm sorry, I did not give it to her. 2c. During an observation, on 3/3/20 at 8:26 a.m., of the Resident 83's morning medication administration (med pass) at Station 4 Medication Cart 2, the licensed vocational nurse (LVN 13) did not administer one (1) morning dose of [MEDICATION NAME] ([MEDICATION NAME], a medication used to depression, obsessive-compulsive disorder, and panic disorder) Capsule 20 mg, which the surveyor identified after the med pass upon verification of the medication orders. A review of Resident 83's Order Summary Report, dated 3/2/20, indicated an order for [REDACTED]. During an interview, on 3/3/20 at 10:33 a.m., LVN 13, regarding the [MEDICATION NAME], acknowledged that she did not administer it and stated, I am waiting for the refill, sir. A review of the facility's pharmacy policy and procedures, titled, Administering Medications, effective date (NAME)2016, indicated, Definition .Medications must be administered in accordance with orders. The licensed nurse must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The expiration date on the medication label must be checked prior to administering.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to: 1. Ensure that three (3) containers of external medications stored separately from internal medications, in two (2) out of three (3) medication carts, out of six (6) total medication carts at the facility. This deficient practice had the potential for cross contamination of external medications with the oral medications, and for the potential for the residents to receive contaminated oral medications. 2. Ensure that two (2) containers of hazardous materials were stored separately from the medications, in two (2) out of three (3) medication carts, out of six (6) total medication carts at the facility. This deficient practice had the potential for cross contamination of hazardous materials with the medications, and for the potential for the residents to receive contaminated medications. 3. Ensure that the one (1) container of a house supply medication was not removed from the medication cart and was not actively administered to the residents when the expiration date was not visible and unknown, in one (1) out of three (3) medication carts, out of six (6) total medication carts at the facility. This deficient practice had the potential for harm to resident due to the potential loss of strength of a medication that has potentially expired, and the potential for the resident to receive ineffective medication dosages. Findings: 1a. During an observation, on [DATE] at 3:04 p.m., the Station 1 Medication Cart B inspection with the licensed vocational nurse (LVN 12) indicated that two (2) tubes of [MEDICATION NAME] Sodium (a medication indicated for treatment of [REDACTED]. During an interview, on [DATE] at 1:58 p.m., LVN 12, regarding the storage of an external formulation touching and co-located with an oral medication and a medical food supplement, stated, OK, we will take it out. After acknowledging that external medications should not be in contact with oral medications and oral supplements for ingestion, LVN 12 stated, We'll fix that right now. 1b. During an observation, on [DATE] at 1:58 p.m., the Station 3 Medication Cart 1 inspection with the licensed vocational nurse (LVN 11), one (1) bottle of Sarna Anti-Itch External [MEDICATION NAME] Lotion, net weight 7.5 fluid ounces (222 ml), was touching one (1) container of Fiber Powder Dietary Supplement, net weight 13 oz. (368 grams) and one (1) bottle of [MEDICATION NAME] (a medication indicated for the treatment or prevention of [MEDICATION NAME], the tightening of muscles that line the airways in the lungs, contributing to asthma symptoms like wheezing and shortness of breath) Syrup, 2 mg per 5 ml, 1 pint (473 ml) bottle, and co-located in the same compartment of the same drawer with other medications. During an interview, on [DATE] at 2:08 p.m., the LVN 12, regarding storage of an external formulation touching and co-located with two oral medications for ingestion, acknowledged that an external lotion should not be touching oral medications for ingestion, stated, OK, I will put them in the treatment cart A review of the facility's pharmacy policy and procedures, titled, Storage of Medications, effective date (NAME)2008, indicated, Procedures: Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. 2a. During an observation, on [DATE] at 3:02 p.m., the Station 1 Medication Cart B inspection with the licensed vocational nurse (LVN 12) indicated that one (1) bottle of Hydrogen Peroxide (a mild antiseptic used on the skin to prevent infection of minor cuts, scrapes, and burns) 3% (strength as percentage concentration), 16 fluid ounces (473 ml) was in direct physical contact, touching one (1) bottle of Pro-Stat (medical food designed for the dietary management of wounds and other conditions requiring increased protein in low volume) Sugar Free 30 fluid ounces (887 ml), one (1) bottle of Cytra-K (Potassium [MEDICATION NAME] 1100 mg and Citric Acid 334 mg per 5 ml Solution, a medication indicated for the long-term maintenance of an alkaline urine when desirable, such removing uric acid for gout therapy), labeled 450 ml, one (1) bottle of [MEDICATION NAME] Powder for Solution, Osmotic Laxative, 8.3 ounces (2.3 grams), and one (1) bottle of UTI Stat, 30 fluid ounces (887 ml), and co-located in same compartment of the same drawer with other medications. During an interview, on [DATE], at 3:58 p.m., LVN 12, regarding a hazardous chemical touching and co-located with a medical food supplement and an oral medication for ingestion, stated, OK, we will take it out. After acknowledging that a hazardous chemical should not be in contact with an oral supplement and an oral medication for ingestion, LVN 12 stated, We'll fix that right now. 2b. During an observation, on [DATE] at 1:51 p.m., the Station 3 Medication Cart 1 inspection with the licensed vocational nurse (LVN 11) indicated one (1) can of Airworks Air Freshener (flammable aerosol, [MEDICATION NAME], Liquified Petroleum Gas) net weight 7 ounces (199 grams) touching one (1) bottle of Milk of Magnesia (a medication indicated for the treatment of [REDACTED]. During an interview, on [DATE] at 2:08 p.m., LVN 11, regarding storage of a hazardous chemical with two (2) oral medications for ingestion, acknowledged that an aerosol air freshener should not be touching medications and stated, OK, I will put them in the treatment cart. A review of the facility's pharmacy policy and procedures, titled, Storage of Medications, effective date (NAME)2008, indicated, Procedures: Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies; disinfectants are clearly identified and stored in a locked area separately from medications. 3. During an observation, on [DATE] at 2:54 p.m., the Station 1 Medication Cart B inspection with the licensed vocational nurse (LVN 12) indicated one (1) bottle of [MEDICATION NAME] Extra-Strength Pain Reliever 500 mg Tablet, labeled 100 tablets per bottle, had no visible manufacturer's expiration date. During an interview, on [DATE] at 2:58 p.m., the LVN 12, regarding no visible expiration date on label of manufacturer's bottle, stated, I can't see it, somehow it got erased. A review of the facility's pharmacy policy and procedures, titled, Procedures for All Medications, effective date (NAME)2008, indicated, Procedures: Check expiration date on package/container. A review of the facility's pharmacy policy and procedures, titled, Storage of Medications, effective date (NAME)2008, indicated, Procedures: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, for without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.
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.**

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 150 residents who receive food from the kitchen of 151 residents in the facility by failing to: 1. Ensure the door handle of the walk-in refrigerator was intact and did not have a broken piece to keep the door closed shut. 2. Ensure the inside left top part of the walk-in freezer did not have ice accumulation (ice build-up). 3. Ensure the frozen foods inside the walk-in freezer were not stored not passed the red line. 4. Ensure the dry storage room supplies were stored not passed the red line. 5. Ensure personal belongings of dietary staff were not stored inside the kitchen. These deficient practices had the potential to compromise the integrity of the food and placed residents at risk for foodborne illnesses (illness caused by the ingestion of contaminated food or beverages). Findings: During the Kitchen Initial Tour Observation, on 3/2/20, at 10:59 A.M., with the Dietary Supervisor (DS), the following were observed: 1. The door handle of the walk-in refrigerator had a broken piece to keep the door closed shut. 2. The inside left top part of the walk-in freezer have ice accumulation (ice build-up). 3. The frozen foods: one (1) box of hash brown, two (2) big bins of ice cream, and one (1) box of blueberries located inside the walk-in freezer were stored passed the red line. 4. One box of emergency supplies and a 1 box of portion cup lids were stored passed the red line inside the dry storage room. 5. One (1) bottle of lotion was observed stored inside the kitchen located by the glass window beside the ice machine. During an interview, on 3/2/20, at 11:35 A.M., the Dietary Supervisor (DS) acknowledged that the door handle of the walk-in freezer should not have a broken piece to keep the door closed shut. The DS stated she did not report the missing piece on the door handle to the administrator nor the maintenance department, as they already knew about it. The DS agreed that the inside left top part of the walk-in freezer should not have ice build-up; the frozen foods should not be stored past the red line; all the supplies should not be stored past the red line inside the dry storage room; and also no personal belongings stored inside the kitchen. A review of the facility's Policy and Procedures, titled Cleaning Instructions: Refrigerators, with review date 3/20/19, indicated for walk-in refrigerators and freezers, ensure all door latch mechanisms are working and door completely closes on its own. A review of the facility's Policy and Procedures, titled Dry Storage Area, with review date 3/20/19, indicated all items must be stored at least 6 inches off the floor. Shelving should be built at least 2 inches from walls and 18 inches from the ceiling. There must be adequate space on all sides of stored items to permit ventilation. A review of the facility's Policy and Procedures, titled Cleaning Instructions: Freezers, with review date 3/20/19, indicated for walk-in freezers, mop floors, wash walls and ceilings as needed. Store all foods at least 6 inches from the floor and 18 inches from the ceiling. Allow room between food items for air circulation. A review of the facility's Policy and Procedures, titled Personal Hygiene and Belongings Policy, with review date 3/20/19, indicated street clothing, coats, purses, packages, and other personal effects will be stored in employee lockers and not in the kitchen.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of one resident (Resident 335) by: 1. Failing to accurately assess the resident's pressure ulcer (PU-localized damage to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure) upon admission. 2. Failing to accurately assess the resident's PU upon discharge. These deficient practices had the potential for Resident 115 at risk for inappropriate care and management of his pressure ulcers due to inaccurate and incomplete resident medical care information. Findings: a. A review of Resident 335's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 335's Minimum Data Set (MDS - a residents' assessment and screening tool) dated 2/14/20, indicated the resident had severe impairment in cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required extensive physical assistance from staff for bed mobility, transfer, dressing, personal hygiene, eating and toileting. A review of Resident 335's Weekly Pressure Ulcer Report (WPUR-assessment & measurement of pressure ulcer), dated 2/9/20 indicated the resident was admitted to the facility with a coccyx (aka tailbone, a small triangular bone resembling a shortened tail located at the bottom of the spine) Pressure Ulcer (PU-localized damage to the skin and/or underlying tissue, usually over a bony prominence, resulting from sustained pressure) Stage 1 (intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area). The WPUR's Undermining (caused by erosion under the wound edges, resulting in a large wound with a small opening) was left blank. b. A review of Resident 335's WPUR, dated 2/14/20 indicated the resident was discharged from the facility with a coccyx PU Stage 1. The WPUR's Undermining, Necrotic Tissue Type (dead cells or black area in a PU), Necrotic Tissue Amount (NTA-non-viable tissue due to reduced blood supply), [MEDICATION NAME] (a process that covers the wound with [MEDICATION NAME] tissues) were left blank. A review of Resident 335's WPUR, dated 2/14/20 indicated the resident was discharged from the facility with Left Heel PU Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough (dead tissue usually cream or yellow in color) may also present as an intact or open/ruptured serum-filled blister). The WPUR's Stage/Depth (the actual measurement by classification and the deepest anatomic type of soft tissue damaged), Undermining, NTT, Granulation Tissue (pink in color & maybe an indicator of healing), [MEDICATION NAME] were left blank. During an interview, on 3/4/20 at 10:37 A.M., the Assistant Director of Nursing (ADON) verified that the WPUR assessments of Resident 335 upon admission and upon discharge should not show as in-progress and should be completed on the PCC (Point-Click-Care, computer software used for documentation of WPUR). The ADON agreed that the WPUR assessment are accurate if left with no holes, gaps or blanks. During an interview, on 3/5/20 at 9:09 A.M, the Licensed Vocational Nurse 14 (LVN 14) stated that she leads the two treatment nurses in the weekly wound meetings every Friday and she receives the Weekly Pressure Sore Log (WPSL- a facility form for reporting PU during the meetings). LVN 14 verified that she does not check nor see if the WPUR assessments on the PCC were shown as completed. A review of the facility's Policy and Procedures (P&P), titled Charting and Documentation, with review date 3/20/19, indicated objective observations is to be documented in the residents' medical record. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff implemented infection prevention measures by failing to: 1. Perform hand hygiene while providing pressure ulcer treatment for one (Resident 14) out of three residents reviewed under the pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) care area. This deficient practice placed the resident at risk for infection and cross contamination; and had the potential to result in delayed healing of the pressure ulcer. 2. Ensure staff's personal belongings were not placed in the same clothing rack where residents' clean personal clothing and blankets were stored, reviewed under Infection Control Task. 3. Ensure hand hygiene was done right after handling the soiled linens before touching the dryer. These deficient practices had the potential for cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface to another) among residents in the facility. Findings: a. A review of Resident 14's admission record (face sheet) indicated the resident was initially admitted to the facility on [DATE], from a general acute care hospital (GACH), and most recently readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 14's Minimum Data Set (MDS-a standardized assessment and screening tool) dated 11/26/2019, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated the resident had two unstageable pressure ulcers present during admission. A review of the Physician Orders indicated an order dated 0[DATE]20 to change dressing every Monday, Wednesday, and Friday. Irrigate wound with normal saline, pat dry with 4x4, apply Santyl ointment then place [MEDICATION NAME] dressing to fit the wound base. Trim vacuum foam to fit within wound cavity, cover with transparent dressing with a small hole in the middle, place trac pad then attach tubing to a wound vac at 125 millimeter of mercury (mmhg-unit of measurement) every shift every Monday, Wednesday and Friday. During a treatment observation of Resident 14's Stage 4 pressure ulcer on the sacro (bottom of the spine)-coccyx (tail bone) area on 03/04/2020 at 11:10 AM, Certified Nursing Assistant 4 (CNA 4) did not perform hand hygiene after taking off her gloves after providing incontinence care to the resident. CNA 4 went to get a trash barrel from the soiled room and placed the barrel outside the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555822	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON OAKS NURSING AND REHABILITATION CENTER	**22029 SATICOY STREET CANOGA PARK, CA 91303**

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) room. CNA 4 then donned a new pair of gloves without performing hand hygiene and proceeded to assist Licensed Vocational Nurse 7 in turning the resident to his left side for the treatment. During the same observation, LVN 7 was observed washing her hands before and after the treatment. However, during the treatment, LVN 7 was observed changing gloves four times while irrigating and cleaning the wound with Normal saline without performing hand hygiene in between glove changes. LVN 7 was not able to place the place the [DEVICE] (device that removes pressure over the area of the wound) during the observation due to resident stated he was tired and would like to rest and resume treatment at a later time. During an interview with CNA 4 on 03/04/2020 at 11:39 AM, CNA 4 stated hand hygiene or hand washing should be performed after touching soiled linen, dirty diaper, after cleaning the resident. During an interview with LVN 7 on 03/03/2020 at 12:45 PM, LVN 7 stated that handwashing is performed before putting on gloves and removing gloves after removal of the old dressing and again after completion of the treatment. There is no handwashing in between gloving during application of treatment and new dressing. During an interview with the Director of Staff Development (who is also the facility's Infection Preventionist Nurse) on 03/04/2020 at 12:00 PM, she stated that hand washing should be performed before and after gloving. During an interview with the Director of Nursing (DON) on 03/04/2020 at 12:16 PM, the DON stated that the staff had in-service training on hand hygiene and wound care and that the staff is aware that hand washing should be performed before and after donning gloves. A review of the facility policy and procedure titled, Using Gloves, reviewed on 03/20/2019, indicated that non sterile gloves should be used primarily to prevent contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces. Wash hands after removing gloves (Note: gloves do not replace handwashing). b. During an observation on 03/04/2020, at 08:15 a.m., in folding area of the laundry service areas, there was an employee's jacket, personal bag, and juice jar that contained juice on the second rack that was for the residents' clean clothing and blankets storage. During an interview on 03/04/2020, at 08:30 a.m., with Laundry House Keeping (LHK) 1, LHK 1 stated, employees should not leave any employees' personal items in the rack to store the residents' clean clothing. LHK 1 stated, residents' clean clothing could be contaminated from the employee's personal items. During an interview on 03/04/2020, at 08:30 a.m., with Maintenance Supervisor (MS), MS stated, employees should not leave employees' personal belongings in the clean laundry service areas for the infection prevention and control. c. During a concurrent observation and interview on 03/04/2020, at 08:20 a.m., in soiled linen room, the Laundry House Keeping (LHK) 2 did not perform hand hygiene right after loading soiled linens into the washer. LHK 2 used personal protective equipment with a gown and gloves to handle soiled linens, after she removed gown and gloves, wore new gloves without hand hygiene and touched a dryer. LHK 2 stated, she forgot to wash her hands before wearing new (clean) gloves. During an interview on 03/04/2020, at 08:35 a.m., with Maintenance Supervisor (MS), MS stated, staff should wash their hands after handling soiled linens even though staff used gloves. A review of the facility's policy and procedure (P&P) titled, Laundry and Linen Policy, revised on January 2018, the P&P indicated, Laundry and Nursing staff should wash hands after handling soiled linen and before handling clean linen. Laundry staff should keep folding area clear of clutter and unnecessary items.