STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055182	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEMON GROVE CARE AND REHABILITATION CENTER	**8351 BROADWAY LEMON GROVE, CA 91945**

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of its staff (S1) treated four out of four residents (1, 2, 3, and 4) with dignity and respect. This failure had the potential for residents to feel unimportant and disrespected. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 2 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 4 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During the investigation of a complaint, on 2/26/20 at 3:30 P.M., an interview was conducted with a resident's family member (FM). FM stated he had concerns about one of the facility's staff members (S1). FM stated he had observed S1 having conversations with people not there, and that he appears to be disturbed or have mental health issues. On 2/28/20 at 9:30 A.M., an interview was conducted with activity assistant (AA) 1. AA 1 stated she witnessed an incident that took place in or around August 2019 involving S1 and a male resident with dementia (medical condition with impaired brain function characterized by memory loss and poor judgement). AA 1 stated the resident had a behavior of repeating words and asking to call the police. AA 1 stated she had been in the dining hall when she heard S1 yell loudly for the resident to Stop! calling out. AA 1 stated she stepped in to the hall and saw S1 with the resident and they were approximately 50 feet away from the dining hall. AA 1 stated it was not appropriate for S1 to yell at a resident. AA 1 stated she did not report the incident to the facility's administrator (ADM) because she assumed other staff had also witnessed the incident. AA 1 stated she should have reported the incident. AA 1 further stated she had received complaints from other residents about S1 yelling at them while they were in group activities. On 2/28/20 at 10:20 A.M., an interview was conducted with certified nursing assistant (CNA) 1. CNA 1 stated she had witnessed S1 when he was stressed. CNA 1 stated when S1 was stressed he had a short temper with residents and would speak to them in a loud angry voice. CNA 1 stated she did not think it was appropriate when S1 did that. On 2/28/20 at 1:30 P.M., a joint interview was conducted with Residents 2 and 3. Resident 2 stated she had concerns about group activities when S1 was present. Resident 2 stated, Something's not right with him in the head. Resident 2 stated S1 made her feel uncomfortable when he talked to himself. Resident 3 stated S1 argued with residents and can be mean. Resident 3 stated she heard him tell a resident to shut up once. Resident 3 stated, He's told me to shut up. Resident 3 stated when S1 told her to shut up, she told S1 not to speak to her like that again. Resident 3 stated, I don't like to judge others, but I don't think someone with mental issues should be working with patients who have issues, too. On 2/28/20, a record review was conducted. Resident 2's Minimum Data Set Assessment (an assessment tool), dated 12/30/19, Brief Interview of Mental Status (BIMS) was reviewed. Resident 2 scored 15 out of 15 (indicating the resident was cognitively intact). Resident 3's Minimum Data Set Assessment, dated 2/17/20, BIMS was reviewed. Resident 2 scored 12 out of 15 (indicating the resident had mild cognitive impairment). On 8/13/20 at 3:30 P.M., another interview was conducted with FM. FM stated Resident 1 had told him that S1 told him to shut up during a group activity. FM stated, Staff shouldn't talk to residents like that. On 8/26/20 at 10:41 A.M., an interview was conducted with Resident 1. Resident 1 stated S1 did not treat him with dignity or respect. Resident 1 stated S1 would yell at him to get out when he was at group activity. Resident 1 stated, I don't like (S1), he's mean. Resident 1 stated S1 had told him once in the group activity to shut up. Resident 1 stated when S1 told him to shut up; it made him feel, Like I'm not important. Resident 1 stated he did not report the incident to his nurse or another staff member because, I didn't feel it was anyone's business. Resident 1's Minimum Data Set Assessment, dated 7/15/20, BIMS was reviewed. Resident 2 scored 9 out of 15 (indicating the resident had moderate cognitive impairment). On 8/26/20 at 11:36 A.M., an interview was conducted with Resident 4. Resident 4 stated she was the vice president of the Resident Council. Resident 4 stated the Resident Council members did not like S1 running the council as he yelled and got easily upset with them. Resident 4 stated, He's crazy, and the littlest things set him off. Resident 4 stated S1 would become overwhelmed at having to do more than one thing at a time, and loses it and starts yelling. Resident 4 further stated she witnessed S1 tell a female resident with a behavior of making noises to shut up. Resident 4 stated S1's behavior was disrespectful and rude. Resident 4's Minimum Data Set Assessment, dated 5/26/20, BIMS was reviewed. Resident 4 scored 15 out of 15 (indicating the resident was cognitively intact). On 8/26/20 at 2:42 P.M., an interview was conducted with S1. S1 stated Resident 1 was having his birthday in February 2020, and had wanted attention. S1 stated Resident 1 tugged on his shirt, and he became frustrated with Resident 1 and told him to shut up. S1 stated telling Resident 1 to shut up was disrespectful and could be considered abuse. S1 stated, I shouldn't have done that . S1 stated he had not told any other residents to shut up, nor had he yelled at any residents. On 8/27/20 at 10:13 A.M., an interview was conducted with the facility's ADM. The ADM stated when a staff member yelled at residents or told residents to shut up, it would be considered abuse. The ADM stated S1's behavior toward Resident 1 was unacceptable and was no way to speak to a resident. On 8/27/20 at 11:45 A.M., an interview was conducted with the director of nursing (DON). The DON stated S1 told her on 8/26/20 that he had told Resident 1 to shut up in February 2020. The DON stated S1 had been disrespectful to Resident 1. The DON stated S1's behavior to the facility's residents had been unacceptable. Per the facility's policy titled Policy/Procedure-Nursing Administration Section: Resident Rights, Subject: Dignity and Respect, dated 5/2007, It is the policy of this facility that all residents be treated with kindness, dignity, and respect . 6. Violations of the Resident's right to dignity and respect should be promptly reported to the Director of Nursing Services and/or the Administrator
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on Interview and Record Review, the facility failed to ensure the result of their investigation, related to an abuse allegation, was reported to the California Department of Public Health (CDPH) within 5 working days of the incident. This failure resulted in the CDPH not knowing the outcome of the facility's investigation regarding the alleged abuse. Findings: The facility reported to the Department an allegation of abuse on 5/4/2020. Per the report, Resident 36 alleged that licensed nurse (LN) 5 inappropriately touched her on 5/2/2020. On 8/27/2020 at 4 P.M., a joint interview and record review was conducted with the Administrator and the Director of Nursing (DON). An undated copy of the facility's Investigative Summary Abuse Allegation, written by the Administrator and the DON, was provided by the facility. The Administrator stated she and the rest of the IDT (Interdisciplinary Team) conducted the Abuse Investigation immediately upon finding out about the alleged abuse but added that she could not recall when she reported the result of the investigation to the CDPH. The

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

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Administrator could not provide documented evidence that the result of their investigation was reported to CDPH within 5 days of the alleged incident. The facility's policy titled: Policy/Procedure - Nursing Administration, Section: Resident Rights, Subject: Abuse Prevention, revised 2/2008, indicated, The Administrator will complete a copy of Abuse Investigating Report, Resident form within five (5) working days of the reported incident .The results of the Investigation will be reported to the Department of Health Services.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. Fall prevention interventions recommended by the interdisciplinary team (IDT) and part of the resident plan of care were implemented for one of three residents (5) who had a recent fall with major injuries. 2. A used [MEDICATION NAME] needle and attached syringe (device used to inject medications through a needle into the body) was safely disposed of. This deficient practice had the potential for Resident 5 to experience further falls with injury. In addition, improperly disposed of needles/syringes had the potential for residents and staff to experience sharps injury (become stuck with a needle) or to be exposed to bloodborne pathogens (infectious microorganisms in human blood that can cause disease). Findings: 1. On 2/28/20 a record review was conducted. Resident 5 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record. Resident 5's history and physical examination [REDACTED]. On 2/28/20 at 8:30 A.M. an observation and interview with Resident 5 was conducted in the resident's room. Resident 5 was in bed, and she could not recall having had a recent fall with injury. Resident 5 did not have a bed alarm (device to notify staff when a resident got up from bed) in place or floor mats (to cushion a fall) placed on either side of the bed. On 2/28/20 at 10:20 A.M., a joint interview and observation was conducted with certified nursing assistant (CNA) 1 of Resident 5. CNA 1 stated residents identified as a fall risk had to have interventions in place to prevent falls. CNA 1 stated some interventions used for residents at risk for falls was to lower the resident's bed, use a bed or chair alarm, and the use of floor mats placed next to a resident's bed. CNA 1 observed Resident 5 in bed and stated the resident did not have a bed alarm or floor mats in place. CNA 1 stated Resident 5 was identified as having a risk for falls. A review of Resident 5's Fall Committee IDT note, dated 2/20/20, indicated, IDT for Unwitnessed Fall on 2/19/20 . Resident was transferred to (hospital name omitted) .Interventions when resident comes back from the hospital: 1. Bed alarm to alert staff. 2. Landing mat to both sides of the bed . A review of Resident 5's undated written care plan with focus on I had a fall with injury . indicated, .Interventions . bed alarm when in bed . floor mat . On 2/28/20 at 2:40 P.M., a joint observation, interview, and record review was conducted with licensed nurse (LN) 5 of Resident 5. LN 5 observed Resident 5 in bed and stated the resident did not have a bed alarm or fall mats in place. LN 5 stated Resident 5 was on the facility's Falling Star Program. LN 5 stated the Falling Star Program identified residents at high risk for falls in order to prevent further falls. LN 5 reviewed Resident 5's Fall Committee IDT note dated 2/20/20, and stated the IDT's recommendations when the resident returned from the hospital had not been followed. LN 5 reviewed Resident 5's revised fall care plan with the focus on I had a fall with injury and stated the fall prevention interventions had not been completely implemented and the written care plan had not been followed. LN 5 stated Resident 5 should have had a bed alarm in place while the resident was in bed and floor mats on both sides of the bed to prevent further falls with injury. On 2/28/20 at 2:45 P.M., a joint interview and record review was conducted with LN 1. LN 1 reviewed Resident 5's written plan of care and Fall Committee IDT note dated 2/20/20. LN 1 stated Resident 5 should have had a bed alarm and fall mats in place when the resident came back from the hospital and currently as they were interventions recommended by the facility's IDT. LN 5 stated Resident 5's fall care plan had not been fully implemented and it should have been in order to prevent further falls. LN 1 stated Resident 5's fall interventions should have been regularly checked by LNs and CNAs to ensure they were in place. On 9/9/20 at 2:56 P.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation that recommendations made by the Fall Committee IDT were to have been carried out. The DON stated it was also her expectation for written fall care plan interventions to be fully implemented. The DON stated Resident 5 should have had a bed alarm and fall mats in place when observed on 2/28/20 as indicated by the IDT notes on 2/20/20 and as per the resident's written fall care plan. Per the facility's policy titled Policy/Procedure -Nursing Administration, Section: Continuum of Care, Subject: Falling Star Program, revised 5/2007, .It is the policy of this facility to reduce the number and severity of falls and to identify high risk residents and take precautionary measures . Interventions .4. Staff to check at beginning of every shift for correct application of i.e., restraints, cushions, wheelchairs, bed rails, etc 2. On 9/1/20 at 7:05 P.M., an observation was conducted on Station 2. An unattended medication cart was placed near the nursing station. A sharps container (secured disposal unit for used needles and syringes) was attached to the side of the medication cart. On top of the sharps container was a syringe with an attached [MEDICATION NAME] needle. No staff were present in the vicinity of the medication cart, or at the nursing station. A female resident ambulated back and forth near the medication cart. On 9/1/20 at 7:10 P.M., a joint interview and observation of the medication cart was conducted with licensed nurse (LN) 7. LN 7 observed the unattended medication cart and the syringe on top of the sharps container. LN 7 stated the syringe and attached [MEDICATION NAME] needle should not have been left in a location where a resident could grab it. On 9/1/20 at 7:12 P.M., a joint interview and observation of the medication cart was conducted with LN 6. LN 6 stated she was assigned to the medication cart and the syringe with attached [MEDICATION NAME] needle had been used to administer medication to a resident. LN 6 stated the used needle and syringe should not have been left hanging out. LN 6 stated the female resident who had been ambulating was confused and could have taken the syringe. LN 6 stated the used syringe/needle should have been disposed of properly inside of the sharps container. On 9/1/20 at 8:30 P.M., an interview was conducted with the director of nursing (DON). The DON stated the used syringe and needle should have been properly disposed of inside of the secured sharps container. The DON acknowledged improperly disposed of needles and syringes could lead to accidental needle stick injuries. Per the facility's policy titled Infection Control Policy, Subject: Sharps Disposal, revised 6/2007, . 1. Contaminated sharps shall be disposed immediately or as soon as feasible into designated containers
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 interview and clinical record review, the facility failed to ensure a bowel and bladder training program was developed and implemented for one (1) of three (3) sampled residents (Resident 212), when Resident 212 experienced episodes of bowel and bladder incontinence. This failure placed Resident 212 at risk for development of urinary tract infections and loss of the opportunity to regain bowel and bladder function. Findings: Resident 212 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident 212's MDS, dated [DATE], indicated that resident's BIMS (Brief Interview for Mental Status) was 5 out of 15 which indicated severely impaired cognitive status. During a review of the clinical record for Resident 212, the Minimum Data Set Assessment (MDS - a resident assessment tool used to guide development of the residents' plan of care based on cognitive and physical function abilities) dated 2/4/2020, indicated Resident 212 was incontinent (involuntary loss of control) of bowel and bladder. Resident 212's bowel and bladder evaluation dated 2/3/2020, indicated Resident 212 was incontinent of bowel and bladder and that the resident was a possible candidate. Resident 212's record did not have documentation of a bowel and bladder training program. During an interview on 8/28/2020 at 2:04 P.M., with LN (Licensed Nurse) 25. LN 25 stated, she was familiar with the facility's Bowel and Bladder Retraining Policy. LN 25 reviewed Resident 212's clinical record and was unable to find documentation that a bowel and bladder retraining was attempted or completed for Resident 212. LN 25 stated, The nurses were doing the bowel and bladder assessments and retraining but it looks like they did not do one for Resident 212. LN 25 stated, Resident 212 should have been on bowel and bladder retraining. During an interview on 9/9/2020 at 11:50 A.M., the MDS nurse stated, she was familiar with the facility's Bowel and Bladder Retraining Policy. The MDS nurse located Resident 212's Bowel and Bladder Evaluation, dated 2/3/2020, which indicated Resident 212 was a possible candidate for Bowel and Bladder Retraining. The MDS nurse was unable to find documentation that Resident 212 was placed on a Bowel and Bladder Retraining Program. The MDS nurse stated, Resident 212 should have been on a bowel and bladder retraining program. During an interview on 9/9/2020 at 12:26 P.M., the

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) DON stated, the expectation was for the LN to assess every resident on admission for bowel and bladder incontinence; after the initial 3 day assessment, the LN would determine if a resident was a candidate for bowel and bladder retraining as per the facility policy and procedure. The DON stated, this way the resident does not develop a urinary tract infection and or skin breakdown. The DON stated, Resident 212 should have been on a bowel and bladder retraining. During a review of the facility's policy and procedure titled, Bowel and Bladder Retraining, dated 5/2007, indicated, It is the policy of this facility that bowel and bladder retraining will be provided for residents with the potential to benefit from such a program. Purpose: To re-train incontinent residents in bowel and bladder control when medically feasible . (2) Record residents' bowel and bladder patterns for three (3) days 24/7 on Elimination Diary Form. (3) On the fourth (4th) day, determine if bowel and bladder retraining is appropriate . (5) Document decision on original Bowel and Bladder Retraining Assessment Form . (6) Notify licensed nurse through Nursing Communication 24 hour Report Book . (8) Address bowel and bladder retraining on residents' care plan . (10) Each incontinent resident must be assessed for potential successful bowel and bladder retraining.
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 observation, interview, and record review, the facility failed to ensure private medical information was kept secure for three of three residents (6, 7, 8). This failure had the potential for private medical information to be accessed by unauthorized persons. Findings: Resident 6 was readmitted to the facility on [DATE], per the facility's Admission Record. Resident 7 was admitted to the facility on [DATE], per the facility's Admission Record. Resident 8 was readmitted to the facility on [DATE], per the facility's Admission Record. On 9/1/20 at 7:05 P.M., an observation was conducted on Station 2. An unattended medication cart was placed near the nursing station. Resident 6's medication card (part of the medication package with resident and prescription information) and medication reordering form with Residents 7 and 8's names and medications on it, was uncovered on top of the medication cart. No staff were present in the vicinity of the medication cart, or at the nursing station. A female resident ambulated back and forth near the medication cart. On 9/1/20 at 7:10 P.M., a joint interview and observation of the medication cart was conducted with licensed nurse (LN) 7. LN 7 observed the unattended medication cart and the medication card and medication reordering form with Residents 6, 7, and 8's information uncovered and readily accessible. LN 7 stated the residents' private medical information should not have been kept uncovered and stored out in the open while unattended by the nurse. LN 7 stated this was a violation of Resident 6, 7, and 8's privacy. On 9/1/20 at 7:12 P.M., a joint interview and observation of the medication cart was conducted with LN 6. LN 6 stated she was assigned to the medication cart and had left Resident 6, 7, and 8's private medical information unsecured while she was away from the cart. LN 6 stated she should not have left the residents' private medical information unattended and exposed. On 9/1/20 at 8:30 P.M., an interview was conducted with the director of nursing (DON). The DON stated private medical information on medication cards or medication reordering forms should not have been left out on the medication cart while unattended by the nurse. The DON stated anyone could have accessed the unsecured resident information. Per the facility's policy titled Policy/Procedure, Section: Resident Rights, Subject: Information, Confidentiality of, revised 10/2007, . Resident records, whether medical, financial, or social in nature, will be safeguarded to protect the confidentiality of the information