STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055170	A. Building B. Wing	09/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pico Rivera Healthcare Center	9140 Verner Street Pico Rivera, CA 90660

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to maintain one of one sampled resident (22) dignity during a shower. This deficient practice of exposing Resident 22's body parts during a shower, to another resident, had the potential to cause embarrassment and lower their self-esteem. Findings: During a shower preparation observation on 9/7/19 at 9:10 a.m., certified nurse assistant (CNA 1 and CNA 2) were observed not to close the privacy curtain, before they undressed, and left the resident uncovered in bed. During observation, CNA 1, and CNA 2 transferred Resident 22 from the bed to a shower chair, while the resident's private body parts were exposed to Resident 59, who was also in the room. After shower, CNA 1 and CNA 2 left Resident 22 uncovered and exposed, after drying the resident. A review of an admission records indicated Resident 22 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/29/19, indicated Resident 22 had severe cognitive (ability to remember, understand, learn and make decisions) impairment with daily decision making, and was dependent on staff for activities of daily living (such as transfers, mobility, toileting, grooming, eating and hygiene). During an interview on 9/8/19 at 10:08 a.m., the director of staff development stated the residents must be covered completely during care to maintain their privacy and dignity because it is their right. During an interview on 9/8/19 at 10:43 a.m., CNA 1 stated I did not cover the resident (Resident 22) during shower preparation and when back in the room. CNA 1 stated Resident 59 was in the room and the privacy curtains were not closed. CNA 1 stated This is dignity and privacy violation. During an interview on 9/8/19 at 11:05 a.m., CNA 2 stated about Resident 22, you are right, I should have provided privacy and dignity during shower preparation and after shower. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's admission packet indicated the residents have the right to privacy and dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide four of 4 sampled residents (22, 54, 68, 79), and or their responsible parties the assistance, and information to formulated an advanced directive (written instructions to express a person's choice on treatment or designate someone else to make healthcare decisions), that was kept in the clinical records. The deficient practice had the potential of not identifying, and honoring Resident 22, 54, 68, and 79 health care wishes. Findings: a. During a witnessed record review on 9/7/19 at 5:05 p.m., social services director (SSD) verified Resident 22 did not have an advanced directives acknowledgment information kept in their medical charts. SSD stated she did not offer the residents with no cognitive (ability to learn, remember, understand and make decisions) impairment an advanced directives information. SSD stated she did not offer the resident's responsible party (RPs), who had cognitive impairment the option to formulate and advance directives. SSD stated she did not inquire from RPs, if the residents had a copy of advanced directives information to provide to the facility. A review of the facility's undated policy titled Advanced Directives, indicated advanced directives: 1. Are defined as written instructions to express a person's choice on treatment or designate someone else to make healthcare decisions. 2. Acknowledgement would be provided to residents and or responsible party upon admission. b. A review of the Physician order [REDACTED]. medical condition into consideration) for Resident 54 dated 6/8/19 indicated section D for Advanced Directive (AD) showed the resident had not formulated an AD. There was no AD acknowledgment form in the chart (medical record). A review of Resident 54's admission records indicated the resident was admitted to the facility on [DATE] and was re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 54's history and physical examination [REDACTED]. During an interview with the Social Services Director (SSD) on 9/08/19 at 3:50 p.m., stated only the POLST was completed and Resident 54 had no AD acknowledgement form in the clinical records. c. A review of Resident 68's POLST dated 6/2/19 indicated section D for Advanced Directive (AD) showed there was no AD. There was no AD acknowledgment form in the chart (medical record). A review of Resident 68's admission records indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 68's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/25/19 indicated the resident had no cognitive impairment (ability to think, understand and make decisions of daily living) for daily decision making. During an interview with the Social Services Director (SSD) on 9/08/19 at 3:48 p.m., she stated Resident 68 was alert and oriented on admission . The SSD stated offering of the AD should be done upon admission together with the POLST and reviewed quarterly as needed. The SSD stated she spoke with the resident's family member at the time of admission but did not document the conversation. d. A review of Resident 79's POLST dated 6/18/19 indicated section D for Advanced Directive (AD) that the resident had no AD. There was no AD acknowledgment form in the chart (medical record). A review of Resident 79's admission records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 79's history and physical examination [REDACTED]. During an interview with the Social Services Director (SSD) on 9/08/19 at 3:51 p.m., stated Resident 79 signed the POLST but there was no AD acknowledgement form completed that was kept in the clinical records. The SSD stated she understood the AD information had to be given to the resident or family representative. A review of the facility's undated policy titled Advanced Directives, indicated advanced directives: 1. Are defined as written instructions to express a person's choice on treatment or designate someone else to make healthcare decisions. 2. Acknowledgement would be provided to residents and or responsible party upon admission.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide comfortable, and safe room temperatures for four of 4 sampled resident (14, 21, 28, 59), who resided in room [ROOM NUMBER], 2, 3, and 4. This deficient practice resulted in Resident 14, 21, 28, 59, who resided in room [ROOM NUMBER], 2, 3, and 4, to complain about feeling cold, had to wear [NAME]ets, be covered with blankets, stay in fetal position, and to feel bad. Findings: During the initial tour on 9/7/19 at 6:03 a.m., Resident 14, 21, 28, and 59, who occupied room [ROOM NUMBER], 2, 3, and 4, stated they felt cold. During a concurrent observation, and interview the following was observed: 1. Resident 14 was observed in bed, in a fetal position with several blankets pulled up to her neck. 2. Resident 21 was observed in bed and the blankets were pulled to her neck. 3. On the same day at 6:09 a.m., Resident 28 stated It is cold. Can you get me a blanket. 4. On the same day at 6:13 a.m., Resident 59 was in room wearing a [NAME]et, a baseball cap, and blankets were pulled to his neck. During an interview on 9/7/19 at 7:48 a.m., Resident 21 stated It is always cold for 2 years. I feel bad. I shiver and have to pull the blanket up to my neck. I told the big man. I was told this is the coldest room in the building. During an interview on 9/7/19 at 8:31 a.m., Resident 59 stated It's cold. That's it. Too many days when asked about the room temperature. During verification of rooms 1, 2, 3, and 4, occupied by Resident 14, 21, 28, 59's temperature requested on 9/7/19 at 11:28 a.m., the maintenance supervisor (MS) stated I don't have a gun thermometer (use the laser sight to focus on the object being measured). I rely on the wall thermostat setting. room [ROOM NUMBER] feels the coldest. The wall thermostat were set at and recorded at 72-73 degrees Fahrenheit (F). MS stated I am going to buy a thermometer right now. MS was not able to verify the actual temperatures for room [ROOM NUMBER], 2, 3, and 4. During temperature verification of room [ROOM NUMBER], 2, 3, and 4 using the Department's thermometer on 9/7/19 at 11:41 a.m., the director of nursing a (DON) and licensed vocational nurse (LVN 1) verified temperatures as followed: room [ROOM NUMBER]: 70.3 degrees F. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER]: 68.1 degrees F. room [ROOM NUMBER]: 69.8 degrees F. Concurrently, the DON stated the residents' room temperatures should be set between 72-81 degrees F. During temperature verification of room [ROOM NUMBER], 2, 3, and 4 using the facility's gun thermometer on 9/7/19 at 12:05 p.m., MS verified temperatures as followed: room [ROOM NUMBER]: 68.0 degrees F. room [ROOM NUMBER]: 62.1 degrees F. room [ROOM NUMBER]: 65.5 degrees F. room [ROOM NUMBER]: 65.4 degrees F. During an interview on 9/8/19 at 10:02 a.m., the director of staff development (DSD) stated the residents must be provided with comfortable room temperatures to prevent them from feeling cold, shivering, and from getting sick. DSD stated signs of the residents feeling cold included remaining in fetal position, and or covering their heads and necks with blankets. A review of the facility's undated policy titled Heating, Cooling, Air Conditioning and Ventilation, indicated to ensure comfortable and safe temperatures, the facility must maintain temperature range of 71 to 81 degrees F. A review of the facility's Maintenance Supervisor Job Description dated 10/12/11, indicated the maintenance supervisor (MS) essential responsibilities and duties was not limited to heating and air conditioning systems according to Federal, State and local regulations.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 2 sampled residents (22, 75), were free from physical restraint (any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria, is attached or adjacent to the resident's body, can not be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body), by: Resident 22, the facility did not follow a physician order [REDACTED]. Resident 75, was restrained without prior attempt at least restrictive for the least amount of time. These deficient practices had the potential to restrict freedom of movement, lowered self-esteem, and dignity for Resident 22, and 75. Findings: a. A review of the admission records indicated Resident 29 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 6/19/19 indicated Resident 29 had severe cognitive impairment for daily decision making, and dependent on staff for activities of daily living (such as transfer, bed mobility, hygiene, grooming, nutrition and toileting). During the following observations on 9/7/19 at 6:14 a.m., 7:13 a.m., 8:21 a.m., 8:55 a.m., 9:10 a.m., and 4:48 p.m., Resident 22's bed was pushed against the wall with one full padded side rail pulled up, and in locked position. During record review on 9/7/19 at 4:44 p.m., a physician order [REDACTED]. During a witnessed observation on 9/7/19 at 4:53 p.m., Resident 22 was in bed. The director of nursing (DON) and the minimum data set nurse (MDSN) verified Resident 22's bed was pushed against the wall, one full side rail was up and in locked position, and a thin floor mat was on the floor. The DON stated the physician order [REDACTED]. A review of the facility's undated policy titled Physical Restraint, indicated less restrictive measures such as lowering the bed, pillows or alarms shall be attempted, the duration of application and resident's response are documented before physical restraints are applied. The licensed nurse shall be responsible to obtain an order for [REDACTED].> (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 09/7/19 at 4:31 p.m., to 5 p.m., during observation Resident 73 was sitting in a wheel chair that was stationed next to the nursing station. Resident 73 had a lap belt across the abdomen, fastened behind the wheelchair that prevented the resident from sitting or standing up. On 09/8/19 at 8:15 a.m., to 11:51 a.m., Resident 73 was observed sitting in a wheel chair stationed next to nursing station one. Resident 73 had a lap belt across the abdomen, fastened behind the chair, which prevented the resident from sitting or standing up. On 09/8/19 at 2:24 p.m., to 2:30 p.m., Resident 73 was in the activity room with a lap belt across the resident's abdomen with straps fastened behind the wheel chair preventing the resident from standing. A review of Resident 75's Admission Records indicated resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 75's history and physical examination [REDACTED]. A review of the restraint assessment form dated 3/18/19, indicated the resident had a self release belt due to a fall. During an interview and record review, the Minimum Data Set (MDS), a standardized assessment and care screening tool, assessment dated [DATE], indicated Resident 75's cognitive skills for daily decision making were impaired, and the resident required extensive to total assistance from staff for activities of daily livings. The MDS assessment dated [DATE] indicated the restraint was used on a daily basis. During a concurrent interview with MDS coordinator stated Resident 75 continuously made several attempts of standing, which was unsafe for the resident. A review of the physician order [REDACTED]. A review of the care plan for restraint dated 8/29/19, indicated Resident 75 was at risk for decrease mobility and a least restrictive measures will be implemented. The care plan interventions indicated to apply the restraint as ordered and to release with direct supervision. On 09/08/19 at 2:06 p.m., during an interview with the director of nursing (DON) stated lap belt was used to prevent Resident 75 from getting out of the bed or wheel chair, when unattended. DON stated Resident 75 could not remove the belt restraint and had the potential of entrapping herself. Don stated Resident 75 had a fall on 3/13/2019. When asked the reason why Resident 75 was restricted or prevented from standing unattended, DON had no comments. A review of Resident 75's clinical records had no documented evidence to show implementation of less restrictive measures prior to placing Resident 75 in a lap belt restraint. Resident 75's clinical records had no documented evidence as to when the lap belt had to be applied, when it had to be removed, and how the skin around the belt had to be assessed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to an undated facility's policy and procedures titled, Physical Restraints indicated to ensure resident's right to be free from any physical restraint imposed for purposes of discipline or convenience and required to treat the resident's medical condition. Restraints shall only be used with a written order from the physician and the order must specify the duration and circumstances under which the restraints are to be used. The policy indicated before initiating physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal body function, the facility staff shall verify that the resident's medical record contains documentation that the resident has given informed consent to the proposed treatment or procedure. Restrains shall be used only when alternative or less restrictive measures have been exhausted to protect the resident from injury. Restraint shall only be used to treat the resident's medical conditions and never for discipline or staff convenience and re-evaluation for the need for restraint shall be documented. Pre-restraining assessment and review had to be determine prior to placing a resident in restraint.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow their abuse allegation reporting policy for one of 1 sampled resident (68). This deficient practice resulted in the facility not notifying the Department of Public Health, and the local law enforcement entity of an alleged abuse allegation for 12 days, when Resident 68 claimed he was burnt with hot water after an argument with a certified nursing assistant (CNA). Findings: A review of the admission records indicated Resident 68 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 4/25/19, indicated Resident 68 had no cognitive (ability to learn, remember, understand and make decisions) impairment with daily decision making. During a quality assurance performance improvement interview on 9/8/19 at 2:35 p.m., the Administrator stated Resident 62's responsible party reported to her and the director of nursing that Resident 62 complained about a CNA, who poured hot water on the resident. When asked if the DPH and local law enforcement entity was notified, the administrator stated No, I did not report. When asked if all government appointed agencies were notified, the Administrator stated I have 24 hours to report any abuse allegation without injury. Concurrently, a review of facility's Abuse Allegation Investigation dated 8/28/19 at 4:00 p.m., indicated CNA had a fight with Resident and poured hot water on the Resident 62. During an interview, translated by front desk staff on 9/8/19 at 3:21 p.m., Resident 68 stated a male nurse poured hot water on his back during care. Resident 68 stated he felt bad. A review of the facility's undated policy titled Abuse Allegation Reporting, indicated mandated reported, an employee who identifies suspected abuse against an individual who is a resident must report the incident to the Department of Public Health, and the local law enforcement entity within 24 hours for non serious bodily injury.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the Long-Term Care (LTC) Ombudsman (resident advocate) of a facility-initiated discharge in a timely manner. Resident 87 was discharged to home on 8/16/19 but the facility notified the LTC Ombudsman on 8/20/19. This deficient practice had the potential for Resident 87 not to be provided with access to an advocate who can inform the resident about their options, and rights. Findings: A review of Resident 87's Admission Records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 9/8/19 at 3:08 p.m., during a concurrent interview and record review, the Social Services Director (SSD) stated Resident 87 was admitted to the facility for rehabilitative services including physical therapy, occupational therapy and speech therapy. The SSD stated she discussed the discharge planning with Resident 87 on the second day of the resident's stay in the facility. The SSD also stated Resident 87 underwent therapy and was eventually discharged to the community on 8/16/19. The SSD stated the discharge was facility-initiated. The SSD further stated the facility notified the LTC Ombudsman via fax on 8/20/19, four days after the discharge. A review of Resident 87's Proposed Transfer/Discharge form indicated a fax confirmation addressed to the LTC Ombudsman dated 8/20/19. A review of the facility's undated policy titled, Notice of Transfer/Discharge from Facility Communication to Ombudsman, indicated, .Facility to notify the local LTC ombudsman at the same time the notice is provided to the resident or the resident's representatives when a facility-initiated transfer or discharge occurs.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 20 sampled residents (54, 62) had a comprehensive person-centered care plan, that included goals, and interventions. Resident 54, did not have a baseline care plan for skin discoloration, and [MEDICAL CONDITION] (swelling). Resident 62, did not have a care plan for utilizing oxygen therapy. These deficient practices placed Resident 54, and 62 at risk for not having a care plan that included appropriate and timely interventions to address skin discoloration, [MEDICAL CONDITION], and use of oxygen. Findings: a. On 9/07/19 at 9:36 a.m., during a bed bath with Certified Nurse Assistant (CNA 5), when CNA removed Resident 54's socks, there was [MEDICAL CONDITION] and brown colored discoloration to bilateral (both) lower extremities (legs). A review of Resident 54's admission records indicated the resident was admitted to the facility on [DATE] and was re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 54's history and physical examination [REDACTED]. A review of Resident 54's admission assessment dated [DATE] indicated bilateral lower legs had dark brownish pigmentation and swelling. A review of the resident's baseline care plan dated 8/17/19, had no documentation regarding problem, and intervention on the skin integrity section. During an interview with the MDS nurse on 9/08/19 at 5:58 p.m., stated there was no baseline care plan for Resident 54's skin discoloration and lower leg swelling. The MDS nurse stated interventions could have included elevating the legs, monitoring for the development of pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin), and skin tears. The MDS nurse stated the baseline care plan needed to be completed within 48 hours. A review of an undated facility's policy titled Baseline Care plan indicated nursing facilities are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. b. During an observation on 9/7/19 at 7:45 a.m., Resident 62 was observed receiving oxygen at 2 liters per minute (L/min) via nasal cannula (a tube transferring oxygen to the nose). A review of an admission records indicated Resident 62 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 8/1/19, indicated Resident 62 had severe cognitive impairment (ability to learn, understand, make decisions and remember) for daily decision making. During an interview, and witnessed record review on 9/7/19 at 3:20 p.m., a physician order [REDACTED]. However, a review of the Resident 62's medical chart did not show a care plan for the use of oxygen therapy. During an interview, licensed vocational nurse (LVN 4) stated I don't see it, when asked to locate Resident 62's care plan for oxygen use. LVN 4 stated a care plan was a tool that directed the resident's care, intervention and treatment goals. LVN 4 stated a care plan was initiated as soon as a concern was identified for Resident 62 and updated as necessary. A review of the facility's undated policy titled Baseline Care Plan, indicated changes and updates would be done on the baseline care plan as needed and may include other care plan generated during the interdisciplinary team (relating to more than one branch of knowledge). A review a care plan titled [MEDICAL CONDITION] dated 6/14/19, indicated to apply oxygen as needed and ordered, and to monitor oxygen saturation.

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Pico Rivera Healthcare Center	9140 Verner Street Pico Rivera, CA 90660

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview,and record review, the facility staff failed to meet professional standards of quality for four of 4 sampled residents (3, 31, 73, and 60) by: 1. Ensure pain medication ([MEDICATION NAME]) was administered to Resident 3 by the same nurse who prepared the medication and signed by the staff who administered the medication 2. Follow proper techniques for monitoring blood sugar checks for Residents 31 and 73. 3. Ensure blood pressure was checked before administering two hypertensive (blood pressure) medications for Resident's 60. These deficient practices had the potential for discrepancies in pain medication for Resident 3, obtaining inaccurate blood sugar values that might lead to inaccurate insulin coverage for Residents 31, and 73, and lead to low blood pressure for Resident 60. Findings: a. On 09/07/19 at 08:09 a.m., during medication pass observation, licensed vocational nurse (LVN 3) asked LVN 4 for [MEDICATION NAME] (strong pain medication) 5-325 milligrams (mg) for Resident 3, who complained of having pain 8 out of 10, on a pain rating scale (0 meaning no pain, and 10 meaning the worst pain experienced). LVN 4 did not ask for the location and characteristic of pain, and proceeded to give the [MEDICATION NAME] 5-325 mg, 1 table to LVN 3, who took the medication toward Resident 3's room. LVN 4 signed the Medication Administration Record [REDACTED]. A review of Resident 3's Admission Records indicated readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 8/21/2019, indicated Resident 3's cognitive skill for daily decision making were intact. The MDS also indicated, the resident required extensive assistant with one person for activities of daily living. A review of the physician order [REDACTED]. A review of the pain flow sheet dated 9/1 to 9/7/2019, and the controlled drug record dated 8/28 to 8/30/2019 and 9/1/to 9/7/2019, indicated Resident 3 complained of pain 8/10 on a pain rating scale. However, the pain flow sheet indicated [MEDICATION NAME] 5-325 mg one table was given on 9/7/2019 at 8:30 a.m., and it showed LVN 4's initials. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/07/19 at 04:21 p.m., during an interview with LVN 4, stated before administering pain medication, the residents had to be assessed for pain, the location of pain and characteristic of pain, before preparing the medication prior to administration. LVN 4 stated medication should be given only by the licensed nurse who assessed, prepared and gave the medication to ensure the resident had received the medication. LVN 4 stated that way the same licensed nurse was responsible for any side effect and accountability for that resident. When asked if Resident 3 took the [MEDICATION NAME] 5-325 mg, LVN 4 stated she could not tell if the resident actually took the medication. LVN 4 stated LVN 3 who gave the medication should had documented in Resident 3's MAR, and not LVN 4, to avoid inaccuracy in documentation. On 09/08/19 at 08:02 a.m., during an interview with LVN 3 stated she made an error by given the [MEDICATION NAME] 5-325 mg to Resident 3, which was prepared by another nurse (LVN 4), could be considered falsification. b. On 09/07/19 at 06:26 a.m., during blood sugar monitoring observation for Resident 31, LVN 3, who wiped Resident 3's third finger once with alcohol prep gauze, pricked the finger with lancet, and collected the first drop of blood on to the strip. LVN 3 did not allow the alcohol to air dry and did not wipe the first drop of blood prior to obtaining a reading. The blood sugar reading from the machine registered at 141 milligram per deciliter (mg/dL). A review of Resident 31's Admission Records indicated she was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 31's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 6/20/2019, indicated the resident's cognitive skills for daily decision making were intact, The MDS also indicated the resident required extensive to total assistant from staff with activities of daily living. A review of the physician for Resident 31 dated 8/25/2019, indicated to administer Insulin regular Human solution, inject as per sliding scale: if 60-150 = 0 unit 151-200 = 4 units 201 250 = 6 units 251-300 = 8 units 301-350 = 12 units 351-400 = 14 units, and if greater than 401, give 16 unit, and notify physician if blood sugar is above 400 or below 60 mg/dl, subcutaneously ((SQ) under skin) before meal and at bed time for diabetes mellitus (may give orange juice (8 oz) or glucose gel by mouth if blood sugar below 60 mg/dL. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 09/07/19 at 06: 39 a.m., during blood sugar check observation for Resident 73, LVN 3 pricked the resident's finger with lancet, collected the first drop of blood on to the strip. LVN 3 did not allow the alcohol to air dry and did not wipe the first dropped of blood before obtaining the blood sugar levels. The blood sugar reading from the machine was 185 milligram per deciliter, which was covered with 5 units of [MEDICATION NAME] (insulin). A review of Resident 73's Admission Record indicated the resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS assessment dated [DATE], indicated Resident 73's cognitive skills for daily decision making was intact, The MDS also indicated the resident required extensive assistance with activities of daily living. A review of the physician order [REDACTED]. On 9/8/2019 at 7:45 a.m., during an interview, when asked LVN 3 acknowledged and stated Resident 31 and 73's finger had to be scrubbed for at least one minute with alcohol prep, allowed it to dry, wipe the first drop of blood, then collect the second drop of blood because the second drop of blood would give accurate blood sugar reading. LVN 3 stated not using appropriate technique had the potential of endangering the resident's health because the blood sugar readings maybe inaccurate. On 09/08/19 at 02:58 p.m., during an interview with director of nursing (DON) stated an in-services regarding blood sugar monitoring and insulin administration of medication was given to license staff on 5/30/2019. DON stated staff had to wipe the finger with the alcohol pad three times, air dry, prick the finger, clean the first drop of blood and then collect the second drop of blood. d. During a medication pass observation for Resident 60 on 9/08/19 at 8:59 a.m., Licensed Vocational Nurse (LVN 5) administered the following medications: [REDACTED] 1. Aspirin 81 milligrams (mg), one tablet via gastrostomy tube (([DEVICE]) a tube inserted through the abdomen that delivers nutrition directly to the stomach) 2. [MEDICATION NAME] 25 mg, one tablet for hypertension (high blood pressure) via [DEVICE] 3. [MEDICATION NAME] 20 mg, one tablet for fluid retention via [DEVICE] 4. Renavite vitamin one tablet via [DEVICE] 5. [MEDICATION NAME] 25 mg one tablet for hypertension via [DEVICE] 6. [MEDICATION NAME] 10 milliliter suspension via [DEVICE] (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/08/19 at 10:46 a.m., during an interview, LVN 5 stated she did not take Resident 60's blood pressure prior to administering anti-hypertensive medications, [MEDICATION NAME], and [MEDICATION NAME] in the morning. LVN 5 stated [MEDICATION NAME] was a beta blocker (used to slow down the heart rate), anti-hypertensive. A concurrent review of Resident 60's bubble pack (drug packaging) indicated no parameters for blood pressure prior to administering [MEDICATION NAME]. LVN 5 stated when an order was received, the staff should have clarified with the physician (MD) if there were any parameters or monitoring for blood pressure to reduce the risks of side effects. During an interview with the Director of Nursing (DON) on 9/08/19 at 2:22 p.m., stated when a resident was on an anti-hypertensive medication, the blood pressure was checked prior to administration depending on the MD order. The DON stated if the anti-hypertensive did not have parameters, the nurse administering the medications should had called the MD, especially when there were multiple medications used for hypertension. The DON stated the possible side effects could be [MEDICAL CONDITION] (low blood pressure) due to poly pharmacy. According to the National Institute of Health (NIH), the patient's heart rate and blood pressure should be generally monitored while using beta blockers https://www.ncbi.nlm.nih.gov/books/NBK 6/

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow the physician order [REDACTED]. This deficient practice had the potential of resulting in [MEDICATION NAME] toxicity for Resident 73, such as muscle weakness, twitching, blurred vision, confusion and dehydration and could affects the flow of sodium through nerve and muscle cells. Findings: A review of Resident 73's Admission Records indicated the resident was admitted [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/3/2019, indicated Resident 73's cognitive skills for daily decision making was intact. The MDS also indicated the resident required extensive assistance with activities of daily living with the help of two staffs. A review of Resident 73's history and physical assessment form dated 6/11/19 indicated the resident had the capacity to understand and make decisions. A review of the physician order [REDACTED]. A review of the physician order [REDACTED]. A review of the laboratory test result for Resident 73 dated 6/17/2019 indicated [MEDICATION NAME] value of 0.9 milliequivalent per liter at a range of 0.5 to 12. A review of the Medication Administration Record [REDACTED]. On 09/08/19 at 11:21 a.m., during an interview with LVN 7 stated not monitoring the serum [MEDICATION NAME] levels as ordered increases the likelihood Resident 73 would have muscle weakness, increased heart rate, and potential for dehydration. LVN 7 confirmed the last [MEDICATION NAME] levels should have been done on 8/17/19, but unfortunately, the facility failed to carry out the ordered. According to the facility's policy and procedures titled Medication Order dated 4/2008, indicated the facility must comply with all the legal requirements for a physician's medication order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 2 sampled residents (54), who needed assistance with personal hygiene and bathing, was given a proper bed bath by following the procedures according to their policy, and abiding by standard precautions (set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin, and mucous membranes). This deficient practice of not following the facility's bed bath procedures, and not following standard precautions, potentially placed Resident 54 at risk for not having a clean body and at risk for spread of infections. Findings: On 9/07/19 at 9:31 a.m., Certified Nurse Assistant (CNA 5) was observed inside Resident 54's room preparing to assist the resident with personal hygiene and dressing. During an interview on 9/07/19 at 9:36 a.m., the CNA 5 stated she was going to provide a full bed bath to Resident 54. CNA 5 was observed to have prepared two wash basins at the bedside table and stated one basin had soap and water and the other only contained clean water. During observation, CNA 5 removed Resident 54's incontinent brief (diaper) soaked with urine, with gloved hands. CNA 5, using the same gloves took a towel, soaked it in soapy water and used it on the resident's right leg, before using a clean towel to dry the legs. CNA 5 was then observed to clean the resident's perinea area (private parts) using a towel soaked in the soapy water, took another towel, soaked in clean water to rinse the resident and then took the same towel used to dry the leg to dry the perinea area. CNA 5 then proceeded to clean the other parts of the resident's lower extremities. CNA 5 put a clean diaper on Resident 54, applied lotion to the lower extremities and then put on the pants. On 9/07/19 at 9:52 a.m., CNA 5 was observed to take a towel, soaked in rinse water which had been unchanged from the start of the procedure, and cleaned Resident 54's face. A review of Resident 54's admission records indicated the resident was admitted to the facility on [DATE] and was re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 54's history and physical examination [REDACTED]. During an interview with the Director of Staff Development (DSD) on 9/08/19 at 4:34 p.m., stated the proper procedure for a bed bath included using two basins of water, wash cloths, towels, soap and water and change of clothes or gowns. The DSD stated the procedure requires that residents be cleaned from the cleanest part to the dirtiest part of the body, which meant starting from the face downwards. The DSD stated if cleaning the resident was started from the bottom, the staff should change gloves, change the water in the basins, change washcloths, wash hands, and put on a new set of gloves. The DSD stated there could be an introduction of bacteria or infection if bed bath was done from the bottom of the body to the face. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated facility's policy titled Bed Bath, indicated to first wash the resident's face, neck and ears, then the shoulder, armpit, arm and hand. After laying a towel across the resident's chest, wash the resident's abdomen, then wash the leg and foot, especially the skin between the toes. The policy indicated to repeat for the resident's other leg and foot, and to empty the wash basin and refill with clean warm water.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 3 sampled residents (35, 60) received the calculated amount of enteral feeding as ordered by the attending physician. This deficient practice had the potential to result in Resident 35, and 60's unplanned weight loss. Findings: a. A review Resident 35's Admission Records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 35's History and Physical assessment form dated 6/12/19 indicated the resident did not have the capacity to understand and make decisions. A review of Resident 35's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 6/21/19 indicated the resident was totally dependent with one-person staff assistance with activities of daily living including dressing, eating, toilet use and personal hygiene. The MDS assessment indicated Resident 35 received nourishment through a tube (surgically inserted through the stomach). A review of Resident 35's Physician order [REDACTED]. The order indicated to turn the pump on at 12 noon and turn off at 8 a.m. However, on 9/7/19 at 6:38 a.m., during an observation, Resident 35's tube feeding was running at 46 ml/hr, with a total volume infused at 802 mL. On 9/7/19 at 6:49 a.m., during a concurrent observation and interview, Registered Nurse (RN 2) stated the rate of Resident 35's enteral feeding was at 46 mL per hour and the total volume delivered was 811 mL. RN 2 also stated the resident's enteral feeding starts at 12 noon and ends at 8 a.m. the following day. On 9/7/19 at 9:22 a.m., during a concurrent observation and interview, RN 1 stated the total volume of enteral feeding delivered to Resident 35 was 923 mL. RN 2 stated the enteral feeding was completed for now and will restart at 12 noon. On 9/8/19 at 6:21 a.m., during an observation, Resident 35's enteral feeding was running at 46 mL per hour. The total volume delivered was 759 mL. On 9/8/19 at 6:25 a.m., during an interview, Licensed Vocational Nurse (LVN 10) stated she changed Resident 35's enteral feeding bottle that morning, at 4:45 a.m. LVN 10 also stated every time she changes the enteral feeding bottle, she checked the rate on the pump and documents it on the bottle. LVN 10 further stated the rate of Resident 35's enteral feed was 46 mL per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/8/19 at 1:52 p.m. during an interview, LVN 5 stated she stated she had changed Resident 35's enteral feeding bottle several times before. LVN 5 stated she checks the rate on the pump every time she changes the enteral feeding bottle and labeled the bottle with 46 mL/hr. On 9/8/19, at 2:01 p.m., during a concurrent interview and record review, LVN 5 stated she did not check the physician order [REDACTED]. LVN 5 also stated she was not aware the rate of enteral feeding for Resident 35 was at 50 mL per hour. LVN 5 verified and stated the enteral feeding rate was changed on 8/23/19 by the attending physician but the order was never carried out. LVN 5 further stated Resident 35 was not getting the adequate calories as ordered since 8/23/19 and it had the potential to result in weight loss. A review of the facility's undated policy and procedure titled, Enteral Feeding Monitoring, indicated, .This facility will ensure that the total enteral feeding prescribed is administered as ordered .Licensed nurse will check physician's orders [REDACTED]. b. During a facility tour on 9/07/19 at 5:19 p.m., Resident 60 was observed lying on bed with a gastrostomy ((GT) an artificial external opening into the stomach for nutritional support) feeding of Nephro 1.8 calories (Cal) per liter (L) running at the rate of 50 milliliters per hour (ml/hr). A review of Resident 60's admission records indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview with Certified Nurse Assistant (CNA 4) on 9/08/19 at 11:33 a.m., the CNA stated Resident 60 was able to eat by mouth and was on a GT. CNA 4 stated the resident received meal trays three times a day but would eat small amounts or have no appetite to eat. CNA 4 stated maybe the GT feeding made the resident feel full. During an interview and record review with Licensed Vocational Nurse (LVN 8) on 9/08/19 at 2:41 p.m., stated Resident 60 was on a regular textured, consistent carbohydrate (CCHO), no added salt (NAS) with thin liquid diet. LVN 8 stated the food was not only for oral gratification. A review of Registered Dietician (RD) notes for Resident 60 dated 9/3/19 indicated to change the tube feeding from Nephro at 45 cubic centimeters (cc, same unit of measure as milliliter) which provided 810 kcal or 450 cc over 10 hours to Nephro 50 cc to provide 900 kcal or 500 cc. A review of the dietary supervisor summary recommendations from RD dated 9/2/19 indicated for Resident 60, with a decrease in weight, the recommendation was to change the TF order to Nephro 1.8 at 50 cc/ hr to provide 800 kcals or 500 cc. A review of a physician (MD) order dated 9/4/19 indicated Resident 60 was ordered Nephro 1.8 cal/ml at 50 ml/hr to run for 20 hours via GT to provide 900 cc or 1000 kcal (amount of calories) per day. Turn on at 12 noon and off at 8 a.m. During a telephone interview with Registered Nurse (RN 1) on 9/08/19 at 2:58 p.m., stated RD recommendations were followed by the MD when it came to change a GT feeding order. RN 1 stated she obtained the GT order change from the RD and wrote the MD order. Regarding the discrepancy between the RD recommendation and the MD order, RN 1 stated she must have made a mistake and missed the discrepancy when looking at RD's recommendation.

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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 obtain a physician order [REDACTED]. This deficient practice resulted in Resident 62 administered oxygen without a physician order, and blood oxygen levels not monitored while recieving oxygen at two liters per minute (2 L/min). Findings: During an observation on 9/7/19 at 7:45 a.m., Resident 62 was observed recieving oxygen at 2 L/min via nasal cannula (a tube transferring oxygen to the nose). A review of an admission records indicated Resident 62 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Mminimum Data Set (MDS), a standardized assessment and care-screening tool, dated 8/1/19, indicated Resident 62 had severe cognitive impairment (ability to learn, understand, make decisions and remember) for daily decision making. During a witnessed record review on 9/7/19 at 3:20 p.m., a physician order [REDACTED]. However, a review of the Resident 62's medical chart, indicated the resident did not have a care plan for oxygen therapy. Concurrently, licensed vocational nurse (LVN 4) stated I don't see it, when asked to locate Resident 62's care plan for oxygen use. LVN 4 stated a care plan is a tool that directed the resident's care, intervention and treatment goal. LVN 4 stated a care is initiated as soon as a concern is identified on a resident and updated as necessary. A review of the facility's undated policy titled Baseline Care Plan, indicated changes and updatesx would be done on the baseline care plan as needed and may include other care plan generated during the interdisciplinary team (IDT, relating to more than one branch of knowledge). A review a care plan titled [MEDICAL CONDITION] dated 6/14/19, indicated to apply oxygen as needed and ordered, and to monitor oxygen saturation.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure four of 4 sampled residents (5, 22, 40, 75), who had an order for [REDACTED]. These deficient practices resulted in Residents 5, 22, 40, receiving initial order for PRN [MEDICAL CONDITION] that extended beyond the 14 days, without the attending physician or prescribing practitioner evaluated the residents for the appropriateness of the medications, and administering [MEDICAL CONDITION] medication to Resident 75 who was diagnosed with [REDACTED]. Findings: a. A review of an admission records indicated Resident 5 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 5/22/19, indicated Resident 5 did not have cognitive (ability to remember, understand, learn and make decisions) impairment for daily decision making. During a witnessed record review by licensed vocational nurse (LVN 9) on 9/8/19 from 7:22 a.m., the physician order [REDACTED].>Resident 5 was on [MEDICATION NAME] (antianxiety) 1 milligram (mg) every (q) 6 hours (hrs) as necessary (PRN) for anxiety, started on 4/5/19, which had no end date. b. A review of an admission records indicated Resident 22 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/29/19, indicated Resident 22 had severe cognitive impairment for daily decision making, and was dependent on staff for activities of daily living (such as transfers, mobility, toileting, grooming, eating and hygiene). During a witnessed record review by licensed vocational nurse (LVN 9) on 9/8/19 from 7:22 a.m., the physician order [REDACTED].>Resident 22 was on [MEDICATION NAME] 0.5 mg 1 tab q 12 hrs prn, which started on 7/31/19 but did not have an end date. c. A review of the admission records indicated Resident 40 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 6/27/19, indicated Resident 40 had moderate cognitive impairment for daily decision making. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a witnessed record review by licensed vocational nurse (LVN 9) on 9/8/19 from 7:22 a.m., the physician order [REDACTED].>Resident 40 was ordered [MEDICATION NAME] (antianxiety) 0.5 mg 1 tab po q 6 hrs prn for anxiety, which started on 4/5/19 but had no stop date. Concurrently, the consultant pharmacist's medication regimen review dated 5/1/19 and 5/15/19, indicated Resident 40 was on prn [MEDICATION NAME] beyond the 14 day limit, and documented the need to extend or discontinue the order. A follow through typed note indicated note was written to physician. Concurrently, LVN 9 stated initial prn [MEDICAL CONDITION]'s are good for 14 days after which the resident had to be re-evaluated by the physician to either discontinue or continue with the medication. A review of the facility's undated policy titled Psychotherapeutic Medications, indicated all prn medication orders are to be discouraged. d. A review of Resident 75's Admission Records indicated resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 75's history and physical examination [REDACTED]. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/8/19, indicated Resident 75's cognitive skills for daily decision making were impaired, and the resident required extensive to total assistance from staff for activities of daily livings. The MDS indicated the resident had dementia and was using [MEDICAL CONDITION] medication. A review of the physician's orders [REDACTED]. 1. [MEDICATION NAME] to give 7.5 milligram (mg) by mouth at bedtime for depression manifested by (M/B) poor appetite ordered 2/1/19,. However, a review of the meal intake flow sheet dated 8/1 to 31/2019 indicated the resident consumed approximately 75 to 90 percent of all the three meals for the day. 2. [MEDICATION NAME] to give 12.5 mg by mouth at bed time every other day for [MEDICAL CONDITION] M/B uncontrollable extreme mood swings cause by anger ordered on [DATE], with drug regimen review conducted on 8/12/19. 3. [MEDICATION NAME] to give 0.5 mg by mouth in the morning for anxiety M/B current restlessness ordered on [DATE] and drug reduction from 1 mg to 0.5 mg on 7/4/19. A review of the Medication Administration Record [REDACTED]. On 09/07/19 at 03:56 p.m., during an interview with licensed vocational (LVN 4) stated the resident had been so sleepy. LVN 4 stated Resident 75 slept during the day and stayed awake at night. LVN 4 stated the resident sleepiness affected her activities of daily living and sometimes did not want to be touched or bothered. LVN 4 stated the resident missed a lot of activity programs. On 09/08/19 at 1:49 p.m., during an interview with the director of the nursing (DON) stated giving [MEDICAL CONDITION] medications to Resident 75 who had dementia, increased the potential of making the resident more confused. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/08/19 at 02:31 p.m., during an interview with the physician stated some other doctor gave Resident 75's the [DIAGNOSES REDACTED]. The physician further stated if the family agreed to the [MEDICAL CONDITION] medication, then it was 'ok' for the resident to take the medication. When the physician was asked if the family members were informed of the side effect that could affect Resident 75 who was diagnosed with [REDACTED].

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to administer insulin to Resident 83 whose blood sugar was elevated as ordered by the physician for one of three sampled residents. This deficient practice resulted to an increase blood sugar level of 415 milligram per deciliters at 11: 30 a. m., for Resident 83. Findings: On 09/07/19, at 6: 55 a. m., during an interview with Resident 83 stated licensed vocational nurse LVN 3 did not monitor her blood sugar on 9/7/2019, at 6: 30 a. m., When the resident was asked how often does the staff monitor he blood sugar, the resident stated four times a day. A review of Resident 83's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 83's history and physical form dated 8/12/19, indicated the resident has the capacity to understand and make decisions. A review of Resident 83's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 6/6/2019, indicated the resident's cognitive skills daily decision making were intact. According to the MDS, the resident required extensive assistance with activities of daily living with one staff. A review of the physician's orders [REDACTED]. if 0 -70 = 0 unit 71 - 150 = 0 unit 151 - 200 = 1 unit 201-250 = 2 units 251 - 300 = 3 units 301 - 350 = 4 units 351 -400 = 5 units if greater than 400 unit notify physician if blood sugar is above 400 or below 60 mg/dl. SQ before meal and at bed time for diabetes mellitus may give orange juice (OJ) 8 ounces or glucose gel by mouth if blood sugar below 60. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Administration Record [REDACTED]. m., the resident's blood sugar read was documented as 213 mg/dl and there was no coverage of the insulin given. However, a review of the sliding scale MAR indicated [REDACTED] A review of the same MAR indicated [REDACTED]. m., indicated a blood sugar value of 415 mg/dl. On 09/07/19, at 07:49 a. m., during an interview with LVN 3 state Resident 83's blood sugar (BS) at 5:05 a. m., When aske, LVN 3 stated the resident was awake and alert when BS was monitored. LVN 3 stated the resident blood sugar value was 213 mg/dl. LVN stated 2 units of insulin was not given as per sliding scale coverage and was supposed to be given before meal. LVN 3 stated the resident had eating her breakfast and the time was 7:51 a. m When asked why the insulin was not administered, LVN 3 stated she forgot to cover the BS value with insulin. LVN 3 stated insulin had to be given before breakfast. B/C some insulin works with food. LVN 3 stated if the insulin was not given before meal or after meal, the resident had the potential of experiencing increase blood sugar, sweating, irritability, shock and diabetes ketose acidosis On 09/07/19, at 12:00 during blood monitor, LVN 4 checked the BS for the resident and the resident's BS value was reading as 415 mg/dl. LVN stated the BS reading is so high, stated I am going to call the doctor. However, a review of the MAR indicated [REDACTED]. m. On 9/8/2019, at 1 p. m., during an interview with the DON stated staff had to follow the physician's orders [REDACTED].

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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 observation, interview and record review, the facility failed to ensure one of two sampled residents (72) were provided with a safe environment during medication administration, when a [MEDICATION NAME] (prefilled, dial-a-dose injectable insulin pen) was left unattended, and one opened vial of [MEDICATION NAME] (medication to correct abnormal blood count) was labeled with an opened date. These deficient practices had the potential of Resident 72 taking a [MEDICATION NAME] that was left unattended, and stuck themselves, and [MEDICATION NAME] expiration date could not be determined. Findings: a. During a medication pass for Resident 40 on 9/07/19 at 6:05 a.m., Licensed Vocational Nurse (LVN 6) was observed to check the resident's blood sugar. Resident 40's blood sugar was determined to be 117 milligrams per deciliter (mg/dL). Based on the resident's blood sugar sliding scale (refers to the progressive increase in the pre-meal or night time insulin (a hormone made by the pancreas that allows the body to use sugar) dose, with pre-defined blood glucose ranges), the resident was to receive 1 unit of [MEDICATION NAME](a rapid-acting human insulin used to lower blood sugar) through a [MEDICATION NAME] (prefilled, dial-a-dose injectable insulin pen). On 9/07/19 at 6:19 a.m., LVN 6 was observed to take a basket filled with multiple residents [MEDICATION NAME] and insulin vials from the medication cart. LVN 6 retrieved Resident 40's [MEDICATION NAME] from the basket, left the basket of [MEDICATION NAME] on top of the cart and went into Resident 40's room. LVN 6 closed the resident's privacy curtain, which made it impossible to visually see the medications that were left on the medication cart. On 9/7/19 at 6:25 a.m. Resident 72 was observed walking around the hallway along Resident 40's room. The resident was observed to stop outside several rooms, then continue walking the hallway. During a concurrent interview with LVN 6, she stated the resident was confused and had a history of [REDACTED]. A review of Resident 72's records indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 72's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 8/7/19 indicated the resident only required supervision for locomotion (walking) on the unit. A review of Resident 72's care plan dated 6/4/19 indicated the resident was at risk for self-injury secondary to being confused about location, did not follow re-direction and would go out of the facility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 6 on 9/07/19 at 7:33 a.m., stated she took the [MEDICATION NAME] the medication cart and left the basket with other residents' insulin vials and other [MEDICATION NAME] when she was in Resident 40's room, with the privacy curtain pulled, which made it impossible to see the basket from inside the resident's room. LVN 6 stated Resident 72 wandered, went in and out of othere resident's rooms, was confused and could have taken one of the insulin pens and stuck herself. b. During Medication Room inspection on 9/8/19 at 9:37 a.m., on East Station medication room refrigerator, one bottle of a multi dose (several) partially used [MEDICATION NAME] (medication to correct abnormal blood count)10,000 units had a broken seal but did not show an open date. Concurrently, licensed vocational nurse (LVN 8) stated we are supposed to indicate an open date on the vial because it is good for so many days after opening, may interfere with potency and affectivity. A review of the facility's undated policy titled Vials and [MEDICATION NAME] of Injectable Medications, indicated The date opened and the initials of the first person to use the vial are recorded on multi dose vial vials.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure menus were followed for 15 of 15 sampled residents (63, 37, 288, 11, 75, 23, 41, 16, 38, 36, 22, 17, 55, 52, 12), who were on puree diets, when: 1. Puree vegetables was served hot, at 145 degrees Fahrenheit (F), instead of being served cold (below 41 F), on 9/7/19. 2. Puree tuna salad was not prepared to be served on 9/7/19, as indicated on the facility's menu, instead was substituted with puree chicken. These deficient practices had the potential to affect Resident 63, 37, 288, 11, 75, 23, 41, 16, 38, 36, 22, 17, 55, 52, and 12's nutritional intake when foods were not served according to the menu. Findings: On 9/7/19 at 4:17 p.m., during an observation, Dietary Aide (DA 1) was preparing puree vegetables containing cabbage and beets using a blender. DA 1 heated the puree vegetables after blending it and placed it on the steam table. On 9/7/19 at 4:47 p.m., during a concurrent trayline observation and interview, the Dietary Services Supervisor (DSS) checked the temperature of the food items on the steam table, which included the following: - puree vegetables: 145 F. - puree meat: 165 F. The DSS stated the puree meat was chicken. On 9/7/19 at 4:55 p.m., the DSS and DA 1 started plating the food for the residents. The DSS plated hot puree vegetable and puree meat to the following residents: 63, 37, 288, 11, 75, 23, 41, 16, 38, and 36. A review of the facility's Summer Menus dated 9/7/19 indicated tuna salad was the main entree for dinner. However, the Summer Menu did not indicate puree chicken as part of the menu. On 9/8/18 at 9:33 a.m., during an interview, the DSS stated the puree vegetable was served hot. The DSS also stated DA 1 prepared the puree vegetable and heated it after blending the vegetables. DA 1 stated puree vegetable should have been served cold. The DSS also stated the puree meat was an alternative for those who did not like the tuna salad. The DSS stated DA 1 did not prepare enough tuna salad to make it into a puree. The DSS stated the menu was not followed for the dinner meal on 9/7/19. The DSS further stated there were 15 residents (63, 37, 288, 11, 75, 23, 41, 16, 38, 36, 22, 17, 55, 52, 12) who received puree meat, instead of puree tuna salad and hot puree vegetable instead of cold puree vegetable. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure titled Daily Food Temperature Control, indicated, .All cold foods shall be held for service at temperatures 40 degrees or below .Food items that are not within proper temperature will be discarded . A review of the facility's undated policy and procedure titled, Menu indicated, .Menus shall be planned, written and posted at least one week in advance .If any meal served varies from the planned menu, the change and the reason for the change shall be noted on the written menu .

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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 follow standard precautions (the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered), and antibiotic stewardship policy for two of 2 sampled residents (22, 29). The deficient practices had the potential for spread of diseases, cross contamination for Resident 22, and inaccurate laboratory culture report and misuse of antibiotic (antimicrobial, medication to treat infections) for Resident 29. Findings: a. During a shower preparation observation on 9/7/19 at 9:10 a.m., certified nurse assistants (CNAs 1 and 2) were observed wearing clean gloves, before removing Resident 22's soaked incontinent briefs (diaper) with urine, closed and opened privacy curtains, and touched the restroom door knob with the same potentially contaminated gloves. CNA 2 was observed closing the door to Resident 22's room with the same contaminated gloves after helping CNA 1 to remove the urine soaked diaper. CNA 1 was observed opening and remove a bottle of shampoo from Resident 22's closet with the same contaminated gloves. CNA 1 removed the contaminated gloves. CNAs 1 and 2 did not change gloves nor remove gloves and perform hand hygiene (procedures include the use of alcohol-based hand rubs and hand washing with soap and water) in between tasks. CNA 1 was observed take a wash cloth from a clean linen cart without performing hand hygiene first. During the same observation, while in the shower room, CNA 1 was observed wearing clean gloves, washed Resident 22's private area and bottom, and then washed the resident's head and face with the same potentially contaminated gloves. CNA 1 did not change gloves nor perform hand hygiene inbetween the tasks. A review of an admission records indicated Resident 22 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/29/19, indicated Resident 22 had severe cognitive (ability to remember, understand, learn and make decisions) impairment for daily decision making, and was dependent on staff for activities of daily living (such as transfers, mobility, toileting, grooming, eating and hygiene). During an interview on 9/8/19 at 10:08 a.m., the director of staff development (DSD) stated CNAs are aware to shower a resident starting with the head, moving down to the toes, and wash the private area and bottoms last because those areas are considered contaminated. DSD stated I can't use contaminated gloves especially after washing private parts and bottom then wash a resident's face, this is infection control, cross contamination. The DS stated No, you can't touch anything until you remove contaminated gloves and perform hand hygiene. During an interview on 9/8/19 at 10:43 a.m., CNA 1 stated acknowledged and stated she must remove the contaminated gloves and perform hand hygiene after knowing the hands or gloves were potentially contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/8/19 at 11:05 a.m., CNA 2 stated You are right. I am sorry. It will not happen again. when interviewed on infection control during Resident 22's shower preparation. b. A review of the admission records indicated Resident 29 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool dated 6/19/19 indicated Resident 29 had severe cognitive impairment for daily decision making. During an interview, and record review on 9/7/19 at 5:07 p.m., licensed vocational nurse (LVN 8) stated Resident 29 was [MEDICATION NAME](antimicrobial, medication to treat infections), [MEDICATION NAME] (antimicrobial) and [MEDICATION NAME] (antimicrobial) for left abdominal drainage. Concurrently, a physician's orders [REDACTED]. abdominal wound. Concurrently a review of the Medication Administration Record [REDACTED]. During an interview on 9/8/19 at 8:49 a.m., LVN 9 stated If we need to obtain a sample for diagnostic tests, I remind staff not to administer antibiotics before collecting specimens, to prevent false positive and or negative laboratory results, which could result in bacteria antibiotics resistance. During an interview on 9/8/19 at 9:02 a.m., LVN 7 stated I got the order from the physician to start antibiotics. However I did not inform the charge (licensed) nurse that a wound culture was required prior to start of antimicrobials. A review of the facility's undated policy titled Antimicrobial Stewardship Program, indicated it is the facility's policy to implement an antimicrobial stewardship program would focus on a coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents, and track whether a culture was obtained before ordering antibiotic.