| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055135 | A. Building<br>B. Wing | 04/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Montrose Healthcare Center | 2123 Verdugo Blvd.<br>Montrose, CA 91020 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview and record review, the facility failed to provide reasonable accommodation of need for two of four sampled resident (Resident 27 and Resident 14) who were at risk for fall, by failing to ensure the residents call light was within reach as indicated in the facility's policy and procedure, titled Call Lights and resident's Care Plan.<br><br>These deficient practices had the potential for Resident 27 and Resident 14 not to receive or received delayed care to meet the necessary care and services that could result in fall and accident.<br><br>Findings:<br><br>a. During a review of Resident 27's Admission Record, the admission record indicated the facility admitted Resident 27 on 3/24/2023 with diagnoses that included history of falling.<br><br>A review of the Minimum Data Set (MDS- a resident assessment and care screening tool) dated 3/27/2024, indicated Resident 27 had no cognitive (ability to remember and process information) impairment that requires supervision or touching assistance and helper provides verbal cues on toileting and personal hygiene.<br><br>During a review of Resident 27's History and Physical assessment dated [DATE], indicated Resident 27 has the capacity to understand and make decisions.<br><br>During a review of Resident 27's Care Plan titled Fall Risk, dated 3/29/2023, the Care Plan indicated Resident 27 was at risk for fall due to history of falling. The Care Plan interventions indicated for the nursing staff to place Resident 27's call light within easy reach.<br><br>During a review of Resident 27's Care Plan titled Falling Star Program, dated 4/13/2023, the Care Plan indicated Resident 27 was at risk for fall due to history of falling, muscle weakness and difficulty in walking. The Care Plan interventions indicated for the nursing staff to place Resident 27 ' s call light within easy reach.<br><br>During a review of Resident 27's Care Plan titled Actual Fall, dated 11/17/2023, the Care Plan indicated Resident 27 was at risk for fall due to history of falling, The Care Plan interventions indicated for the nursing staff to attached call light to bed within access of Resident 27.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 4/19/2024 at 5:46 pm, Resident 27 was sitting on her wheelchair. Resident 27 ' s call light was placed at the head of Resident 27 ' s bed. Resident 27 stated, she could not reach the call light and wanted to ask her nurse to clean her bed.<br><br>During a concurrent observation and interview on 4/19/2024 at 5:47 pm, with Registered Nurse 1 (RN 1), the RN 1 stated Resident 27's call light was not in reach. In an interview RN 1 stated, call light was needed to be within reach for Resident 27 to use to call for help when she needed assistance. RN 1 stated, Resident 27 ' s call light needed to be in reach to maintain Resident 27's safety.<br><br>b. During a review of Resident 14's Admission Record, the admission record indicated the facility admitted Resident 14 on 11/12/2020 with diagnoses that included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks).<br><br>During a review of Resident 14's Care Plan titled Falling Star Program, dated 11/27/2020, the Care Plan indicated Resident 14 was at risk for fall due to history of falling, muscle weakness and osteoarthritis. The Care Plan interventions indicated for the nursing staff to place Resident 24's call light within easy reach.<br><br>During a review of Resident 14's Care Plan titled Fall Risk, dated 11/27/2022, the Care Plan indicated Resident 14 was at risk for fall due to muscle weakness, osteoarthritis (type of joint disease that results from breakdown of joint cartilage [connective tissue] and underlying bone). The Care Plan interventions indicated for the nursing staff to place Resident 14 s call light within easy reach.<br><br>During a review of Resident 14's History and Physical assessment dated [DATE], indicated Resident 14 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 14's MDS, dated [DATE], the MDS indicated, Resident 14's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated, required maximum assistance with shower, lower body dressing and putting on/taking off footwear.<br><br>During a concurrent observation on 4/19/2024 at 6:06 pm, Resident 14 was sitting on her wheelchair. Resident 14's call light was observed hanging on the cabinet next to Resident 14's bed. Resident 14 stated I could not reach it.<br><br>During a concurrent observation and interview on 4/19/2024 at 6:09 pm, with Certified Nurse Assistant 1 (CNA 1), the CNA stated Resident 14 ' s call light was hanging on the cabinet. CNA 1 stated Resident 14 was unable to reach the call light. CNA stated call light was needed to be within reach to for Resident 14 to use to call for help.<br><br>During an interview on 4/20/2024 at 1:26 pm, with Director of Nursing (DON), DON stated, call light should be within reach for Resident 14 to call for help if assistance needed and to maintain Resident 14 ' s safety.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a record review of the facility ' s undated policy and procedure (P&P) titled, Call Light the P&P indicated, ensuring that the call light is within the resident ' s reach when in his/her room or when on the toilet. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on interview and record review, the facility failed to provide information of Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.) for one out of two sample residents (Resident 36).<br><br>This failure had the potential to result in the violation of the residents right and the facility staffs to provide medical or surgical treatment against the resident's will.<br><br>Findings:<br><br>During a review of Resident 36's Admission Record indicated Resident 36 was readmitted on [DATE], with diagnoses that included dysphagia (difficult swallowing) and malignant neoplasm of prostate cancer (abnormal cell growth in the gland of male reproductive system).<br><br>During a review of Resident 36's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 2/23/2024, indicated Resident 36 had clear speech, usually understood other and able to make self-understood.<br><br>During an interview and concurrent Resident 36's record review on 4/19/202 at 7:33 pm, the Social Service Director (SSD) stated, there was no information about AD provided to Resident 36 or Resident 36's responsible party. The SSD stated the SSD forgot to screen Resident 36 for AD. The SSD stated it was important to provide information and offer the resident to formulate an AD to know the resident ' s wishes on how they wanted to be medically treated. The SSD stated it was the resident ' s right so the facility would not treat the resident against their wills.<br><br>During a review of the facility's policy and procedure titled, Advance Directives revised 9/2022, indicated, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027<br><br>Based on observation, interview, and record review, the facility failed to ensure two of four sampled resident (Residents 51 and 54) were provided a homelike environment to maintain a comfortable noise level in accordance with the facility ' s Policy and Procedure (P&P), when Resident 12 ' s disruptive behavior of yelling cursing and swearing kept Residents 51 and 54 awake at night and disturbed their sleep.<br><br>This failure resulted in residents 51 and 54 to feel tired and/or frustrated that could potentially result the residents to experience a decline in their health, quality of life and psychosocial (mental and emotional) wellbeing.<br><br>Findings:<br><br>During a review of the facility's daily census report, dated 4/18/2024, the daily census report indicated Residents 12, 51, and 54, were roommates, all residing in the same room.<br><br>During a review of Resident 12's Admission Record (AR), the AR indicated Resident 12 was admitted to the facility on [DATE] with multiple diagnoses including fracture (broken bone) of the right femur (thighbone), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and difficulty in walking.<br><br>During a review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/16/2024, the MDS indicated Resident 12 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 12 was dependent (helper does all the effort to complete the activity) performs on staff for toileting and personal hygiene, bathing, and dressing.<br><br>During a review of Resident 51's AR, the AR indicated Resident 51 was admitted to the facility on [DATE] with multiple diagnoses including sepsis (a serious condition in which the body responds improperly to an infection), acute respiratory failure (when the lungs can't get enough oxygen into the blood) with hypoxia (low levels of oxygen in your body tissues), and difficulty in walking.<br><br>During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 51 required partial/moderate assistance (helper does less than half the effort) from staff for toileting, bathing, and dressing.<br><br>During a review of Resident 54's AR, the AR indicated Resident 54 was admitted to the facility on [DATE] with multiple diagnoses including cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and hypertension (high blood pressure).<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 54 required partial/moderate assistance (helper does less than half the effort) from staff for toileting and oral hygiene. The MDS indicated resident 54 required substantial/maximal assistance (helper does more than half the effort) from staff for dressing and bathing.<br><br>During an interview on 4/19/2024 at 18:45 pm with Resident 54, Resident 54 stated Resident 12 yelled all the time. Resident 54 stated he could not sleep at night because Resident 12 yelled during the night.<br><br>During a concurrent observation and interview on 4/20/2024 at 10:25 am with Resident 51, Resident 12 was observed to be swearing every few minutes. Resident 51 stated that Resident 12 would sometimes wake him up at night or early in the morning due to Resident 12 ' s outbursts. Resident 51 stated Resident 12 cussed all the time because Resident 12 was crazy. Resident 51 stated Resident 51 felt frustrated and mad. Resident 51 stated Resident 51 told the staff everyday about the situation.<br><br>During an interview on 4/20/2024 at 11:15 am with Resident 54, Resident 54 stated Resident 12 swears all the time. Resident 54 stated this had been going on for 3 or 4 days already. Resident 54 stated he could not get any sleep because of resident 12 ' s outbursts of yelling. Resident 54 stated it made him feel lousy during the day.<br><br>During an interview on 4/20/2024 at 11:25 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 12 did have a behavior of outbursts with swearing. The surveyor informed LVN 1 Residents 51 and 54 had complaints of not getting good rest at night because of Resident 12 ' s noisy behavior.<br><br>During an interview on 4/21/2024 at 9:45 am with Resident 51, Resident 51 stated Resident 12 was still disruptive during the previous night. Resident 51 stated he wanted to tell Resident 12 to shut up.<br><br>During an interview on 4/21/2024 at 8:50 am with Resident 54, Resident 54 stated Resident 12 was still waking Resident 54 up during the night. Resident 54 stated it happened again last night.<br><br>During an interview on 4/21/2024 at 9:44 am with the Social Services Designee (SSD), the SSD stated she was not notified on 4/20/2024 that Residents 51 and 54 were not able to sleep due to Resident 12's behavior. The SSD stated Resident 12's behavior did not provide a homelike environment for Residents 51 and 54. The SSD stated residents (in general) could not get good rest at night then they would not feel well and might not want to participate in activities. The SSD stated the residents could feel anxious.<br><br>During a review of the facility's P&P titled, Homelike Environment revised February 2021, the P&P indicated Residents are provided with a safe, clean, comfortable and homelife environment . The P&P indicate, The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: comfortable sound levels. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview and record review, the facility failed to follow the professional standard of care and the facility's policy and procedure on documenting the medication as given right after medication was administered for one out of five residents (Resident 6).<br><br>This failure had the potential to result in medication error and a potential for the residents not to receive medications as prescribed by the physician or the same medication causing decline in the resident health condition.<br><br>Findings:<br><br>During medication administration observation on 4/20/2024 at 8:59 am with Registered Nurse 2 (RN 2), RN 2 completed administering Ceftriaxone (antibiotic or medication to treat bacterial infection) intravenously (IV, refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) to Resident 6. After the medication administration RN 2 did not sign the Medication Administration Record (MAR, a record used to document medications taken by each individual) after administering the medication and walked away.<br><br>During an interview on 4/20/2024 at 9:19 am, RN 2 stated, the MAR was not signed right after administrating the Ceftriaxone to Resident 6. RN 2 stated I will sign right now. RN 2 stated the MAR should signed right after administering medication to the resident, and it was a professional standard of practice and the facility's policy. RN 2 stated, signing MAR right after administrating medication could avoid medication error and prevent the resident receiving double dose which may cause harm to the resident.<br><br>During a review of Resident 6's Admission Record indicated Resident 6 was readmitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and hypertension (increased blood pressure).<br><br>During a review of Resident 6's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 3/8/2024, indicated Resident 6 had clear speech, had ability to understand others and had ability to make self-understood.<br><br>During a review of Resident 6's Order Summary Report as of 4/20/2024, indicated, Resident 6 was prescribed Ceftriaxone 1 gram IV every 24 hours for bacteria in urine for 4 days started on 4/18/2024.<br><br>During an interview on 4/21/2024 at 9:35 am, with the Director of Nursing (DON), the DON stated, medication administration should follow patient ' s right that included, right patient, right medication, right dose, right route and right documentation. The DON stated, the staff should sign MAR right after medication given to avoid medication error.<br><br>During a review of the facility's policy and procedure, titled, Administering Medications, revised 3/2023, indicated, As required or indicated for a medication, the individual administering the medication records in the resident's medical record: the date and time the medication was administered; the signature and title of the person administering the drug. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview and record review, the facility failed to provide indwelling catheter (foley catheter - a tube inserted in the bladder to drain urine into a drainage bag) and ensure foley catheter touching the trash Bin as indicated in the facility ' s policy and procedure, titled Urinary Catheter Care and the resident ' s care plan for one of one sampled residents ( Resident 48) by failing to ensure:<br><br>1. Resident 48 was assessed and monitored the presence of white sediments (visible particles in the urine that may contain red or white blood cells, casts, bacteria, fungi, parasites in the urine that could indicate presence of infection or dehydration [fluid deficit]) and cloudiness in the urine.<br><br>2. The indwelling catheter was not touching the trash bin.<br><br>These deficient practices had the potential for Resident 48 to receive no care or delayed care and treatment for urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system).<br><br>Findings:<br><br>During a review of Resident 48's admission record indicated, the facility admitted Resident 48 on 3/9/2024 with diagnoses that included UTI and retention of urine.<br><br>A review of the Minimum Data Set (MDS- a resident assessment and care planning tool) dated 3/16/24 indicated Resident 48 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) was dependent (helper does all the effort) with staff on toileting hygiene.<br><br>During a review of Resident 48's Physicians Order Notes, dated 3/9/2024, indicated to insert foley catheter French (a type of catheter) 16 (size of the catheter) attached to bedside drainage bag for urinary retention.<br><br>During a review of Resident 48's History and Physical assessment dated [DATE], indicated Resident 48 has the capacity to understand and make decisions.<br><br>During a review of Resident 48's Physicians Order Notes, dated 3/9/2024, indicated to monitor FC urinary drainage bag and document the following: color, consistency, odor, hematuria, bladder distension, burning sensation every shift.<br><br>During a review of Resident 48's care plan titled UTI/Current UTI initiated on 3/9/2024, the care plan indicated Resident 48 was at risk for having recurrent UTI's and urinary retention. The care plan interventions included for the nursing staff to assess for signs/symptoms of UTI such as complaints of pain, burning, increase in frequency and urgency during urination, increased temperature, change in urine character: color, cloudy, odor, amount, clarity, and will notify physician as indicated.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 48's care plan titled Foley Catheter initiated on 3/9/2024, the care plan indicated for staff to monitor Resident 48 ' s urine for sediments, cloudiness, odor, blood and amount of output.<br><br>During an observation on 4/19/2024 at 6:28 pm, Resident 48 was lying in bed. Resident 48 had foley catheter hanging on the right side of bed. Resident 48's foley catheter tubing was cloudy and contained white sediments. Resident 48 ' s foley catheter tubing was touching the trash bin.<br><br>During a concurrent observation and interview on 4/19/2024 at 6:30 pm, with Licensed Vocational Nurse 2 (LVN 2), the LVN 2 stated the FC tubing was cloudy. LVN 2 stated foley catheter needed to be monitored for signs and symptoms of UTI such as presence of sediments and cloudiness by licensed nurses to prevent infection. LVN 2 stated, foley catheter should not be touching the trash Bin to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect).<br><br>During an interview on 4/20/2024 at 1:23 pm with the facility ' s Director of Nursing (DON), the DON stated, licensed nurses needed to monitor the foley catheter every 8 hours to check for presence of blood or sediments, cloudiness, pain in urination and signs and symptoms of UTI to prevent infection. The DON stated, foley catheter should not be touching the trash bin to prevent cross contamination.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Urinary Catheter Care, revised on 8/2022, the P&P indicated, the purpose of the procedure is to prevent urinary catheter associated complications, including urinary tract infections. The P&P indicated to use aseptic technique when handling or manipulating the drainage system and be sure catheter tubing and drainage bag are kept off the floor. The P&P indicated to observe the resident for complications associated with urinary catheter and to report unusual findings to the physician if urine has an unusual appearance and s/s of urinary tract infection. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 6) received care and services for parenteral (liquid solution administered into the vein) antibiotic (a drug used to treat infections caused by bacteria and other microorganisms) consistent with professional standards of practice and the facility's policy and procedure titled General Policy for IV therapy on documentation of intravenous catheter (IV-a plastic device inserted into the vein used to deliver fluids) insertion date<br><br>This deficient practice had the potential for the resident to develop infection and worsen health condition.<br><br>Findings:<br><br>During an observation on 4/19/2024 at 6:13 pm, in Resident 6's room, Resident 6 ' s right hand was wrapped with gauze (a pad covers the IV site) with an IV port (part of the IV catheter that inserted into the skin) protruding out of the gauze. The IV site was not labeled with date of insertion. During a concurrent interview with Registered Nurse 1 (RN 1), RN 1 stated, Resident 6 was receiving Ceftriaxone (antibiotic) IV daily for infection. RN 1 stated Resident 6 ' s IV site should be labeled with date the IV was inserted so that staff knows when to change the IV site to control infections. RN 1 stated, IV sites should be rotated every three days, and labeled, so that the staffs would know when to change the IV site. RN 1 stated, IV sites might get infected if the IV was not changed for extended days. RN 1 stated, it was important to change the IV site for resident ' s health and safety.<br><br>During a review of Resident 6's Admission Record indicated Resident 6 was readmitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and hypertension (increased blood pressure).<br><br>During a review of Resident 6's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 3/8/2024, indicated Resident 6 had clear speech, had ability to understand others and had ability to make self-understood.<br><br>During a review of Resident 6's Order Summary Report as of 4/20/2024, indicated, Resident 6 was prescribed Ceftriaxone 1 gram IV every 24 hours for bacteria in urine for 4 days started on 4/18/2024.<br><br>During a review of the facility's policy and procedure, titled, General Policy for IV therapy, dated 6/2018, indicated, IV peripheral sites will be rotated at least every 96 hours and as needed. A physician ' s order is required to extend the use of an IV site beyond 96 hours, if warranted due to poor venous access. The extensions for continued IV use was not recommended to exceed 7 days. |

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| | 055135 | A. Building<br>B. Wing | 04/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Montrose Healthcare Center | 2123 Verdugo Blvd.<br>Montrose, CA 91020 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>42781<br><br>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 49) received oxygen in accordance with the facility's policy and procedure by failing to:<br><br>1. Resident 49's nasal cannula tubing (flexible plastic tubing with prongs [small opening] used to deliver oxygen through nostrils and fitted over the patient ' s ears) and was touching the trash bin.<br><br>2. Resident 49 was receiving oxygen therapy without a physician's order.<br><br>This deficient practice had the potential to increase the risk of the spread of infection to Resident 49 and at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which can lead to serious complications.<br><br>Findings:<br><br>During a review of Resident 49's Admission Record, the admission record indicated the facility admitted Resident 49 on 1/27/2024 with diagnoses that included acute respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) with hypoxia and pneumonia (infection that inflames the lungs).<br><br>During a review of Resident 49's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/22/2024, the MDS indicated, Resident 49 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 49 required supervision with eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing and personal hygiene.<br><br>During a review of Resident 49's Order Summary Report (OSR), dated 4/20/2024, the OSR did not indicate Resident 49 had an order for oxygen at 2 liters per minute via nasal cannula.<br><br>During an observation on 4/19/2024, at 6:16 pm, with Certified Nursing Assistant 2 (CNA 2), Resident 49 was walking towards her bed and oxygen tubing and nasal prongs was touching the trash bin. The CNA 2 stated oxygen tubing should be off the floor because the floor is dirty and can cause infection.<br><br>During an observation and record review on 4/20/2024, at 11:09 am, with the Registered Nurse 1 (RN 1), Resident 49 ' s OSR dated 4/20/2024 was reviewed. The OSR, did not indicate an order for use of oxygen for Resident 49. The RN 1 stated continuous or as needed use of oxygen required a doctor ' s order to ensure Resident 49 was getting accurate oxygen therapy.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/20/2024 at 1:29 pm with the facility's Director of Nurses (DON), the DON stated oxygen administration needed a doctor ' s order to ensure Resident 49 will not get too little or too much oxygen. The DON stated oxygen tubing should not be touching the trash bin to prevent infection cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect).<br><br>During a review of the undated facility's policy and procedure (P&P) titled, Oxygen Administration, P&P indicated, to review physicians order for oxygen use. The P&P indicated, oxygen tubing should be changed weekly and as needed, including changing the mask, cannula. The P&P indicated, when not in use, the oxygen tubing should be stored in a clean bag. The P&P indicated since oxygen is based on a physician ' s order, it is considered a licensed staff procedure. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Post nurse staffing information every day.<br><br>44027<br><br>Based on interview and record review, the facility failed to post actual worked nursing hours at the start of each shift in the nursing stations visible to the residents and visitors according to the facility ' s Policy and Procedure.<br><br>This failure resulted in the facility inaccurately reflecting the number of staff providing direct care to the residents which could result in the residents not receiving the necessary care they needed.<br><br>Findings:<br><br>During a concurrent interview and record review on 4/20/2024 at 3:57 pm with the Director of Staff Development (DSD), the facility's Daily Staffing Posting dated 4/20/2024 and the facility's 7am - 3 pm staffing assignment, untitled, dated 4/20/2024 were reviewed. The staffing assignment indicated there were 10 Certified Nursing Assistants (CNA) assigned to care for residents during the morning shift. The DSD stated there were 10 CNAs working the morning shift. The Daily Staffing Posting indicated there were only 7 CNAs working the morning shift. The DSD stated she posted the Daily Staffing Posting the night before the shift started and that the Daily Staffing Posting was only the projected number of staff planned for the day. The DSD stated it was not her practice to change the Daily Staffing Posting if there were call offs or staffing changes.<br><br>During a review of the facility's P&P titled, Staffing, Sufficient and Competent Nursing, revised August 2022, the P&P indicated, Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview and record review, the facility failed to ensure medication room free from expired medications for one out of one medication storage room. During a review of the facility ' s policy and procedure, titled, Labeling of Medication Containers, revised 3/2023, indicated, Labels for individual resident medications include all necessary information, such as: the expiration date when applicable.<br><br>This failure had the potential to result in the residents to recieve medications that are not effective to treat their diseases and result in a worsened health condition.<br><br>Findings:<br><br>During an inspection of the facility's medication storage room on 4/20/2024 at 9:23 am, with the Minimum Data Set Coordinator (MDSC), there were two bottles of undated opened Gabapentin oral solution (medication to treat seizures [a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness] and/or neuropathic pain [nerve pain n caused by nervous system malfunction or damage]) in the medication refrigerator, . One opened bottle was labeled with Resident 40 ' s name and the other bottle was labeled with Resident 13 ' s name. During a concurrent interview, the MDSC stated, the prescribed medication should have a label indicating the opened date so that the staff would know when the medication expires or when it should be disposed. The MDSC stated, the prescribed medication expires in 30 days after the medication had been opened. The MDSC stated, it was important to label the opened medication bottle with the date the bottle was opened to know when the medication expires so that the facility staff would not provide expired medication to the resident to ensure resident safety. The MDSC stated, expired medication might not be effective and might affect resident ' s health conditions.<br><br>1. During a review of Resident 40's admission record, indicated Resident 40 was readmitted to the facility on [DATE], with diagnoses that included dysphagia (difficult swallowing) and hemiplegia (weakness on one side of the body).<br><br>A review of the Minimal Data Set (MDS a resident assessment and care screening tool) dated 3/4/2024, indicated Resident 40 had severely impaired cognition (ability to remember and process information). The MDS indicated Resident 40 was dependent (helper does all the effort to complete the activity) performs on staff for toileting and personal hygiene, bathing, and dressing.<br><br>During a review of Resident 40's physician order summary report dated 4/21/2024, indicated, Resident 40 ' s was prescribed Gabapentin oral solution for neuropathic pain.<br><br>2. During a review of Resident 13's admission record, indicated Resident 13 was readmitted to the facility on [DATE], with diagnoses that included dysphagia and cerebral infarction (stroke or interruption of blood flow to the brain).<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 13's physician order summary report dated 4/21/2024, indicated, Resident 13 ' s was prescribed Gabapentin oral solution for neuropathic pain.<br><br>A review of the MDS, dated [DATE], indicated Resident 13 had moderately impaired cognition. The MDS indicated Resident 13 was dependent performs on staff for toileting and personal hygiene, bathing, and dressing.<br><br>During an interview on 4/21/2024 at 9:37 am, the Director of Nursing (DON) stated, all medication that was opened required a label of the date on when it was opened and/or when it should be discarded after 30 days per facility ' s policy. The DON stated, the facility should not provide expired medications to resident to protect resident's safety.<br><br>During a review of the facility ' s policy and procedure, titled, Labeling of Medication Containers, revised 3/2023, indicated, Labels for individual resident medications include all necessary information, such as: the expiration date when applicable. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>40037<br><br>Based on observation, interview and record review, the facility's kitchen staff failed to follow the facility's infection control policies to ensure the department operates under sanitary conditions at all times by failing to wear a hair net (a net worn over the hair to keep it in place) in food preparing area.<br><br>This failure had the potential to result in food contamination and food-borne illnesses (illness caused by consuming food or beverages containing disease causing organisms) to the residents.<br><br>Findings:<br><br>During an observation on 4/19/2024 at 5:36 pm, in the facility's kitchen, Dietary Supervisor (DS) was working in the food preparing area without wearing a hair net. During a concurrent interview, the DS stated that the DS forgot to wear a hair net before entering the kitchen's food preparing area. The DS stated anyone entering the kitchen should wear a hair net before walking in. The DS stated that wearing a hair net could prevent hair from falling in food and cause food contamination. The DS stated that food contamination could put residents at risk for food borne illness.<br><br>During a review of the facility's policy and procedure titled, Sanitation and Infection Control, revised 2019, indicated, Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. A hair net or head covering which completely covers all hair should be worn at all times. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>42781<br><br>Based on observation, interview, and record review, facility failed to follow the facility ' s policy and procedure titled Management and Protection of Protected Health Information, by ensuring one of one sample residents (Resident 34) identifiable, personal and medical information were not exposed on the computer screens unattended and in view of unauthorized persons to view and access confidential information without the resident ' s consent or knowledge.<br><br>This deficient practice resulted in Resident 34 ' s violation of resident ' s right for privacy.<br><br>Findings:<br><br>During a review of Resident 34 ' s admission record indicated, the facility admitted Resident 34 on 6/7/2023 with diagnoses that included anemia (decrease in the total amount of red blood cells in the blood) and neoplasm (abnormal cell growth with the potential to invade or spread to other parts of the body) related to pain.<br><br>During a review of Resident 34 ' s History and Physical (H&P), dated 6/8/2023, the record indicated, Resident 34 had the capacity to understand and made decision.<br><br>During a review of Resident 34 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/31/2024, the MDS indicated, Resident 34 ' s cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 34 required total dependence with toileting, shower, lower body dressing and personal hygiene.<br><br>During an observation of the facility ' s hallway 4/20/2024 at 4:47 pm, one computer screen was observed unattended and logged on, exposing Resident 34 ' s identifiable, personal, and medical information.<br><br>During a concurrent observation and interview with the Licensed Vocational Nurse 3 (LVN 3) on 4/20/2024 at 4:49 pm, LVN 3 stated she went inside Resident 34 ' s room and forgot to log out the computer screen. LVN 3 stated computer screen should not be left opened and unattended exposing residents' information. LVN 3 stated, it was a HIPPA (Health Insurance Portability Accountability Act, a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient ' s consent or knowledge) violation by exposing residents personal and medical information. LVN 3 stated anybody could come and access Resident 34 ' s file and records.<br><br>During an interview on 4/21/2024 at 9:33 am, with the Director of Nursing (DON), the DON stated, staff needed to protect Resident 34 ' s personal records all time to prevent illegal use of information because people passing at the hallway could possibly access to Resident 34 ' s information without the resident's consent.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of facility's Policy and Procedure (P&P) titled Management and Protection of Protected Health Information, revised 4/2014, indicated, it is the responsibility of all personnel who have access to resident and facility information to ensure such information is managed and protected to prevent unauthorized release or disclosure. |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027<br><br>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 14), who signed a Resident - Facility Arbitration Agreement (Binding Arbitration Agreement- is a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds), had the capacity to understand and make an informed decision. Resident 14 signed a Binding arbitration Agreement but did not have the capacity to understand and make decisions.<br><br>This failure had the potential to result in Resident 14 to not be able to make an informed decision and/or her rights to be denied.<br><br>Findings:<br><br>During a review of Resident 14's Admission Record (AR), the AR indicated Resident 14 was admitted to the facility on [DATE] with multiple diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood).<br><br>During a review of Resident 14's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/13/2024, the MDS indicated Resident 14 was moderately impaired in cognitive skills (the ability to make daily decisions and process information).<br><br>During a concurrent interview and record review on 4/20/2024 at 3:06 pm with Resident the Business Office Manager (BOM), Resident 14's Binding Arbitration Agreement, signed 1/22/2024, and Resident 14's History and Physical (H&P), dated 1/8/2024 were reviewed. The Binding Arbitration Agreement indicated Resident 38 signed the document on 1/22/2024. The H&P indicated Resident 14 does not have the capacity to understand and make decisions. The BOM stated the staff who asked Resident 14 to sign the Binding Arbitration Agreement should not have let Resident 14 sign the document. The BOM stated residents who do not have capacity to understand and make decisions do not understand what they are signing.<br><br>During a concurrent interview and record review on 4/21/2024 at 8:37 pm with the Director of Nursing (DON), Resident 14's H&P was reviewed. The DON stated staff should not ask residents (in general) to sign an arbitration agreement if their H&P indicated they do not have the capacity to understand and make decisions. The DON confirmed the facility did not have a Policy and Procedure (P&P) on having residents sign an arbitration agreement. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027<br><br>Based on observation, interview, and record review, the facility failed to ensure infection control practices per facility's Policy and Procedure (P&P) were followed to prevent the transmission of disease and infection for one of five sampled residents (Residents 52).<br><br>The facility failed to place Resident 52 who had a Peripherally Inserted Central Catheter (PICC, a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) on Enhanced Barrier Precautions (EBP, wearing gown and glove during high contact with resident care activities).<br><br>This failure had the potential to result in the spread of infection to Resident 52 while residing at the facility.<br><br>Findings:<br><br>During a review of Resident 52's Admission Record (AR), the AR indicated Resident 52 was admitted to the facility on [DATE] with multiple diagnoses including peritonitis (a redness and swelling of the tissue that lines the belly or abdomen), cancer of the stomach, and surgical aftercare following surgery of the stomach.<br><br>During a review of Resident 52's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/6/23, the MDS indicated Resident 52 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 52 was dependent (helper does all the effort) on staff for toileting, dressing, and bathing. The MDS indicated Resident 52 had a central intravenous (IV, in the vein) access (a small, soft tube put in a blood vessel).<br><br>During a review of Resident 52's care plan titled Risk for Infection, revised on 3/5/2023, the care plan indicated, Provide enhanced standard precaution<br><br>During a concurrent observation and interview on 4/19/2024 at 7:54 pm with the Infection Preventionist (IP), Resident 52 had a PICC line in Resident 52's right arm. Resident 52 was lying in Resident 52's bed. There were no signs on the wall indicating Resident 52 needed EBP. The IP stated Resident 52 should be on EBP since Resident 52 had a PICC line. The IP stated the reason Resident 52 needed EBP was to protect Resident 52 from contracting a multidrug resistant organism (MDRO-disease causing organism that are difficult to treat with antibiotics [ medication to treat infections]) infection. The IP stated resident 52 was at higher risk of getting an infection because Resident 52 had the PICC line. The IP stated there should be signage at the Resident 52's room doorway and on the wall at the head of Resident 52's bed. The IP stated the IP forgot to put Resident 52 on EBP. The IP stated staff could spread a MDRO to Resident 52 since he was not on EBP.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's P&P titled, Enhanced Barrier Precaution undated, the P&P indicated Enhanced Barrier Precaution is infection control intervention designed to reduced transmission of multidrug resistant organism (MDRO) Enhanced barrier Precautions involve gown and glove use during high contact resident care activities for resident known to be infected or colonized with a MDRO as well as those at increased risk of MDRO acquisition (e.g. resident with wounds or indwelling medical devices). The P&P indicated, +All resident will be assessed for the need of Enhanced Barrier Precaution upon admission quarterly as needed with any of the following:<br><br>Active infection (Non-MDRO infection)<br><br>o Colonization (presence of a microorganism on/in a host, with growth and multiplication of the organism, but without interaction between host and organism) with MDRO<br><br>o Any open wound<br><br>o Indwelling (inside the body) medical device. |