STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055182	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemon Grove Care and Rehabilitation Center	8351 Broadway Lemon Grove, CA 91945

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on interview and record review, the facility failed to ensure documentation in the clinical record was accurate for one of two residents (Resident 1) when: 1. Licensed nurses (LN) documented Lithium (a mood stabilizing medication) as having been administered to the Resident 1 when the medication was unavailable. 2. Resident 1 ' s documented behavior monitoring did not reflect accurate observations of the resident ' s behavior. As a result, Resident 1 ' s clinical record did not accurately reflect the care and treatment that was provided. Findings: A review of Resident 1 ' s Admission Record indicated, the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include schizophrenia (mental illness characterized by paranoia, hallucinations, and/or delusions) and acquired absence of left upper limb above the elbow. 1. On 9/5/24, a record review was conducted. Resident 1 ' s readmitting orders from [hospital name] dated 8/19/24, indicated the resident was to take Lithium 300 milligrams (mg) twice a day. A review of Resident 1 ' s medication administration record (MAR) for August 2024 indicated, Lithium 300 mg was given in the morning and evening on 8/20/24, and in the morning on 8/21, 8/23, 8/24, 8/25, 8/26, and 8/27/24. A review of Resident 1 ' s progress notes dated 8/26/24 indicated, Call pharmacy and spoke to [name omitted] regarding medication Lithium Carbonate oral tablet 300 mg. She stated that she doesn ' t see this medication on her side . The progress note further indicated the pharmacy had not dispensed Resident 1 ' s Lithium 300mg as they believed the resident was allergic to Lithium. A review of Resident 1 ' s progress notes dated 8/27/24 at 11:57 A.M., indicated the pharmacy was notified that the nurse practitioner had discontinued the resident ' s allergy to Lithium. The pharmacy was asked again to dispense and send Resident 1 ' s Lithium to the facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemon Grove Care and Rehabilitation Center	8351 Broadway Lemon Grove, CA 91945

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 1:36 P.M., a joint interview and record review was conducted with LN 3. LN 3 reviewed Resident 1 ' s August 2024 MAR and stated he was assigned as the resident ' s medication nurse on 8/25/24. LN 3 stated Resident 1 ' s Lithium was not dispensed from the pharmacy when the resident was readmitted on [DATE] because they thought the resident was allergic to it. LN 3 stated he documented that he gave Resident 1 the Lithium 300 mg at 9 A.M. on 8/25/24. LN 3 stated that documentation was in error. LN 3 stated it was not possible to give Lithium to Resident 1 as the medication had not been dispensed by the pharmacy until 8/27/24. LN 3 removed Resident 1 ' s Lithium 300 mg medication card (individual pills on a card for daily administration) from the medication cart. Resident 1 ' s Lithium medication card was dated 8/27/24 and one dose was empty on the card (#14). LN 3 stated the date of 8/27/24 on the card meant the pharmacy dispensed the medication on that day and that the medication would have been brought to the facility sometime in the evening on 8/27/24. LN 3 further reviewed Resident 1 ' s August 2024 MAR for Lithium 300 mg and stated when LNs documented they gave Lithium in the morning and evening on 8/20/24, and in the morning on 8/21, 8/23, 8/24, 8/25, 8/26, and 8/27/24, that was all in error. LN 3 stated Resident 1 ' s Lithium was not available to give until evening on 8/27/24 or the next day (8/28/24). LN 3 stated the documentation in Resident 1 ' s MAR should have been accurate. On 9/5/24 at 2:23 P.M., a joint interview and record review was conducted with LN 4. LN 4 reviewed Resident 1 ' s August 2024 MAR and acknowledged her documentation on 8/26/24 as having administered Lithium to the resident at 9 A.M. LN 4 stated she could not recall anything about Resident 1 ' s Lithium. LN 4 stated documentation in the residents ' clinical records should accurately reflect care and/or treatment that was rendered. 2. A review of Resident 1 ' s August 2024 medication administration record (MAR) was conducted. Resident 1 was receiving Risperidone (antipsychotic medication to treat psychosis) and had behavior monitoring associated with the medication. The MAR indicated, .Monitor episodes of psychotic behavior AEB [as evidenced by]: striking out toward others (Risperidone) Review of Resident 1 ' s MAR indicated the resident manifested the behavior striking out toward others twice on 8/23/24, five times on 8/24/24, six times on 8/25/24, six times on 8/27/24, and three times on 8/28/24. On 9/5/24 at 1:36 P.M., a joint interview and record review was conducted with LN 3. LN 3 stated he was familiar with Resident 1 and had been the resident ' s assigned nurse on 8/25/24. LN 3 reviewed Resident 1 ' s clinical record and his documentation on the resident ' s MAR on 8/25/24 for Risperidone behavior monitoring. LN 3 stated striking out toward others meant the resident had hit someone or attempted to hit someone. LN 3 stated he had documented this behavior as having occurred 3 times on 8/25/24 and that this documentation had been in error. LN 3 stated he had never seen Resident 1 strike or hit another person, nor attempt to do so. LN 3 stated by inaccurately documenting the resident striking out three times, it appeared there was an issue with this behavior. LN 3 stated if Resident 1 struck or hit someone, this would have needed to be reported to the physician. LN 3 stated the documented observations of Resident 1 ' s behavior should have been accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 1:50 P.M., a joint interview and record review was conducted with LN 5. LN 5 reviewed Resident 1 ' s clinical record and stated striking out toward others meant attempting to or actually hitting another person. LN 5 stated she never saw Resident 1 strike another person. LN 5 stated Resident 1 would swing his amputated arm when walking in a manner that was taunting. LN 5 reviewed her documentation on Resident 1 ' s MAR on 8/23, 8/24, and 8/27/24 and acknowledged she had documented episodes where Resident 1 was observed striking out toward others (twice on 8/23, twice on 8/24, and three times on 8/27/24). LN 5 stated she documented those episodes when Resident 1 moved his amputated arm in a taunting manner. LN 5 stated she did not have a place to document those observations and recorded them as striking out toward others. LN 5 stated she should have clarified the behavior monitoring order. LN 5 stated her documentation should have been accurate and that inaccurately documenting Resident 1 ' s behavior, Gives the wrong idea of the resident ' s behavior. On 9/5/24 at 2:23 P.M., a joint interview and record review was conducted with LN 4. LN 4 stated she saw Resident 1 swing his amputated arm at the corner of his room, but not at anyone. LN 4 reviewed Resident 1 ' s August 2024 MAR and stated she documented Resident 1 as striking out at others three times on 8/26 and three times on 8/28/24. LN 4 stated she did not observe the resident striking at anyone only swinging his amputated arm. LN 4 stated she should not have documented observing Resident 1 swing his amputated arm as striking out at others and that her documentation had not been accurate. On 9/5/24 at 3:11 P.M., an interview was conducted with the director of nursing (DON). The DON stated the LN documentation in Resident 1 ' s MAR should have been accurate. The DON acknowledged Resident 1 ' s Lithium was not dispensed from the pharmacy until 8/27/24. The DON stated LNs should not have been documenting that they gave a medication that they did not give. A review of the facility ' s policy titled Charting and Documentation revised 1/2023, did not provide guidance related to the accuracy of documentation.