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	08/15/2024

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

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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** 47466 39220 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 106) was assisted with a meal in a dignified manner. This failure had the potential for Resident 106 to experience a diminished self-worth. Findings: Resident 106 was readmitted to the facility on [DATE], with diagnoses which included epilepsy (seizures), per the facility's Admission Record. An observation was conducted from the hallway on 8/12/24 at 12:23 P.M. of a staff member feeding Resident 106 in her room. Resident 1 was sitting up in bed and slightly slumped to the right. A staff member was standing on the right side of the bed, feeding the resident a pureed diet (food that has a soft pudding-like consistency). The staff member was standing approximately two feet above the resident's head, looking downward. On 8/12/24 at 12:24 P.M., the staff member was called out from the room. The staff member identified herself as Speech Therapist 1 (ST 1). ST 1 stated she was feeding Resident 106, to assess her swallowing skills. ST 1 stated she was never informed it was proper to feed a resident at eye-to eye level. ST 1 stated sitting at eye level made sense and no one had ever informed her of that. An interview was conducted with Licensed Nurse 31 (LN 31) on 8/12/24 at 12:28 P.M. LN 31 stated all staff should sit while feeding a resident, to promote the resident's dignity. LN 31 stated if staff did not maintain eye level while feeding a resident, the resident could feel intimated and unimportant. An interview was conducted with physical therapy assistant 1 (PTA 1) on 8/12/24 at 3:01 P.M., since the Director of Rehabilitation was unavailable. The PTA 1 stated all residents should be fed at an eye-to-eye level, to promote their dignity. PTA 1 stated ST 1 was currently in her clinical fell owship, a 36-week training period for speech therapy certification. The PTA 1 stated she was unaware if ST 1 received training on proper feeding of residents when hired and PTA 1 will look for any documentation of facility training. (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	On 8/13/24, the PTA 1 was unable to locate any documented evidence ST 1 had facility training related to feeding residents in a dignified manner. On 8/14/24, Resident 106's clinical record was reviewed. According to the 5-day Minimum Data Set (MDS-a clinical assessment tool), dated 7/19/24, Resident 106's cognitive assessment score was 13, indicating cognition was intact. The functional ability's assessment indicated Resident 106 required supervision and assistance while eating. An interview was conducted with the Director of Nursing (DON) on 8/14/24 at 11:05 A.M. The DON stated she expected all staff to maintain eye level with the residents while assisting with meals, because it was a dignity issue. According to the facility's policy titled Dignity and Privacy, dated November 2021, It is the policy of this facility that all residents be treated with kindness, dignity, and respect. 1. The staff shall display respect for Resident's when .caring for .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure privacy was provided to one of 29 residents (Resident 32) during personal care. As a result, there was the potential for Resident 32 to feel embarrassed and distressed. Findings: A review of Resident 32's Admission Record indicated that the resident was admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A review of Resident 32's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 7/16/24, indicated the resident scored 03 on the brief interview of mental status (a score of 03 meant the resident was severely cognitively impaired). On 8/12/24 at 9:40 A.M., an observation was conducted from the hallway outside of Resident 32's room. The door opened to Resident 32's room, and certified nursing assistant (CNA) 50 left the room carrying a bag of soiled items. Resident 32 was visible from the hallway while laying in bed with his knees bent and wearing only a brief (adult diaper) and socks on the lower half of his body. Resident 32 wore a shirt and jacket on his upper body. Resident 32's blankets and sheets were rolled up in a ball at the foot of the bed. On 8/12/24 at 9:47 A.M., licensed nurse (LN) 51 was observed walking to Resident 32's room carrying a pair of jeans. LN 51 went inside Resident 32's room and closed the door. On 8/12/24 at 9:49 A.M., the door to Resident 32's room opened and LN 51 left the room. Resident 32 was observed laying in bed wearing the pair of jeans. On 8/13/24 at 12:07 P.M., an interview was conducted with LN 51. LN 51 stated Resident 32 should have been provided privacy with his curtain drawn so he was not visible from the hallway wearing a brief. LN 51 stated Resident 32 was confused and was not able to verbalize his feelings. LN 51 stated if it had been her, I wouldn't have appreciated that. It's not dignified. On 8/13/24 at 12:23 P.M., an interview was conducted with CNA 50. CNA 50 stated she should have pulled the curtain when leaving Resident 32's room so his brief was not visible to others who were walking in the hallway. CNA 50 stated, I wouldn't have liked that. On 8/14/24 at 3:25 P.M., an interview was conducted with the director of nursing (DON). The assistant director of nursing was also present. The DON stated privacy should have been provided to Resident 32 when he was being changed and dressed. The DON stated the resident's curtain should have been drawn and the door closed. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy titled Resident Rights Subject: Dignity and Privacy, . 3. Residents shall be examined and treated in a manner that maintains privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by . 4. Privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36765 Based on observation, interview, and record review, the facility failed to develop and implement resident-centered care plans related to: 1. Resident 47 was not assessed for activities. 2. Resident 42 was not assessed for triggers related to Post-Traumatic Stress Disorder (PTSD- a condition in which a person has difficulty recovering after witnessing or experiencing a terrifying event). 3. The central port (a line used for dialysis access) was not identified or did not provide direction of care for Resident 32. 4. In addition, turning and repositioning was not implemented for Resident 43. As a result, there was not a consistent approach by staff to address residents' care needs. Findings: 1. Resident 47 was admitted to the facility on [DATE] with diagnoses that included fracture of thoracic vertebra (bones of the spine). A concurrent observation and interview was conducted on 8/12/24 at 11:49 A.M. with Resident 47. Resident 47 was observed sitting in her wheelchair in her room, looking out at the garden and fountain. Resident 47 stated she was bored and did not attend activities because the games were for 2 year olds. An interview was conducted on 8/14/24 at 9:20 A.M. with the Activity Director (AD). The AD stated, This resident does not want to do activities. An activity/interest assessment was never completed and should have been within five days after admission. A review of Resident 47's activities care plan indicated, Resident has little to no involvement in activities . Resident wishes to not participate in any activities . This care plan does not indicate what the facility will do to provide activities the resident does prefer. An interview was conducted on 8/15/25 at 11:25 A.M. with the administrator (ADM) and the Consultant. The consultant stated, Our activities program needs enrichment and we should have assessed her more thoroughly. A review of the facility's policy, dated, 9/13/2023, titled, Care Planning/Care Conference, indicated, Policy: it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident .Procedures: 2. The care plan is developed by the IDT which includes .D. The activity staff member responsible for the resident . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 42 was admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder according to the facility's Admission Record. A concurrent observation and interview was conducted on 8/12/24 at 3 P.M. with Resident 42. Resident 42 was reclining in his bed, watching TV. Resident 42 only wanted to discuss the weather. A review of Resident 42's care plan was conducted on 8/13/24 at 8:30 A.M. The care plan dated 8/21/23, titled PTSD, indicated, .Resident is at risk for re-traumatization R/T diagnosis of Post Traumatic Stress Disorder (PTSD); Resident is unable to identify triggers . The care plan does not identify Resident 42's PTSD triggers. An interview was conducted on 8/13/24 at 3:24 P.M. with the Assistant Director of Nursing (ADON). The ADON stated, We have been unable to identify his triggers. An interview was conducted on 8/14/24 at 8:40 A.M. with certified nursing assistant (CNA) 21. CNA 21 stated, I don't know his (Resident 42) triggers. An interview was conducted on 8/14/24 at 8:43 A.M. with Registered Nurse (RN) 22. RN 22 stated, I don't know his (Resident 42) triggers, but we should know so we can help avoid them or deal with them. An interview was conducted on 8/14/24 at 8:50 A.M. with the Director of Staff Development (DSD). The DSD stated, His (Resident 42) triggers are not known to us, but we should try to find out. An interview was conducted on 8/15/24 at 11:41 A.M. with the Administrator (Adm) and the consultant. The consultant stated, The resident and his family can't tell us his triggers, so we should have explored the diagnosis and the triggers more; the care plan is inadequate. A review of the facility's policy, dated, 9/13/2023, titled, Care Planning/Care Conference, indicated, Policy: it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident . 39111 3. A review of Resident 32's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include end stage renal disease (kidney failure), dependence on renal dialysis (a machine that removes toxins from the blood) per the facility's Admission Record. A review of Resident 32's Renal Dialysis care plan dated 2/13/24 and revised 8/3/24, indicated, Interventions .Check and change dressing daily at access site .Check arteriovenous [AV] fistula [surgical connection of a vein and artery for dialysis] every day for bruit and thrill [a sound and pulsating sensation over a fistula site] . A review of Resident 32's admission note dated 1/19/23, indicated the resident had a tunneled catheter (tube inserted under skin and into a large vein) on the left upper chest for dialysis. There was no mention in the note of the resident having an AV fistula. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 32's medication administration record (MAR) for August 2024 indicated, Monitor permacath [implanted catheter for dialysis access] to [NAME] [left upper chest] to ensure site is intact daily. Dialysis center to maintain catheter. The same MAR indicated, Post dialysis: ([NAME]) check bleeding -Remove pressure dressing [used for a fistula not a catheter] to access site after 4 hours on dialysis days . Refrain from keeping pressure more than 6 hours to minimize risk for access clotting and/or malfunction. The MAR further indicated licensed nurses (LN) were documenting they checked for bleeding and removed a pressure dressing on the resident's dialysis days. On 8/13/24 at 2:45 P.M., a joint interview and record review was conducted with LN 9. LN 9 stated Resident 32 had a permacath in his [NAME] and it did not make sense that someone would apply a pressure dressing to that. LN 9 reviewed Resident 32's August 2024 MAR and stated the LN can check for bleeding but they should not document about removing the pressure dressing because the resident did not have one. LN 9 further stated Resident 32's dialysis care plan was not accurate related to AV fistula and monitoring bruit and thrill. LN 9 stated she did not think Resident 32 had a fistula. On 8/13/24 at 3 P.M., a joint interview and record review was conducted with LN 8. LN 8 reviewed Resident 32's clinical record and stated the resident had a permacath. LN 8 stated the resident's written care plan for dialysis was not resident-specific as the resident did not have an AV fistula and dressing changes were being done at the dialysis center and not in the facility. LN 8 stated it was important for Resident 32's care plan to be resident-specific and accurate to ensure the resident received the right care and treatment. LN 8 stated when care plans were inaccurate, miscommunication of care and errors could occur. On 8/14/24 at 3:25 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 32 did not have an AV fistula and the written care plan for dialysis was inaccurate. The DON stated pressure dressings were not applied to a permacath site. The DON stated dressing changes were not done daily in the facility but done at the dialysis clinic. The DON stated resident care plans should accurately reflect the care provided to the resident and be resident-specific. A review of the facility's policy titled Care Planning/Care Conference reviewed 9/13/23, did not provide guidance related to development of resident-centered care plans. 47466 4. A review of Resident 43's Admission Record indicated that Resident 43 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia (complete paralysis of one side of the body) and Hemiparesis (muscle weakness) and Contractures (shortening of muscles) right and left hand, right and left ankle. A review of Resident 43's undated care plan titled At Risk for skin breakdown, indicated, Turn and reposition every 2 hours. During an observation on 8/14/24 at 7:30 A.M, 10A.M, and 12:15 P.M.,Resident 43 was lying in bed on her right side facing the door. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent observation and interview was conducted on 8/14/24 at 2:15 P.M., with licensed nurse (LN). LN12 stated the staff changed Resident 43 due to Resident 43 was soiled and was repositioned to her right. An interview on 8/14/24 at 4 P.M., with LN 11 was conducted. LN 11 stated Resident 43 should have been turned every 2 hours as indicated in the care plan to ensure the needs of the resident were met. LN 11 stated Resident 43's care plan of turning every 2 hours should have been implemented. An interview was conducted on 8/15/24 at 9:11 A.M.,with the medical records director (MRD). MRD stated the facility did not have a policy on turning and repositioning residents. A record review of the facility's Policy and Procedure on Care Planning/Care Conference revised 9/13/23 did not provide guidance related to implementation of care plans.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36765 Based on observation, interview and record review, the facility failed to provide activities of interest for one of one residents (47) reviewed for activities. This failure had the potential to not maintain or improve Resident 47's physical, mental and psychosocial well-being and independence. Findings: Resident 47 was admitted to the facility on [DATE] with diagnoses that included fracture of thoracic vertebra (bones of the spine). A concurrent observation and interview was conducted on 8/12/24 at 11:49 A.M. with Resident 47. Resident 47 was observed sitting in her wheelchair in her room, looking out at the garden and fountain. Resident 47 stated she was bored and did not attend activities because, The games were for 2 year olds. An interview was conducted on 8/14/24 at 9:20 A.M. with the Activity Director (AD). The AD stated, This resident does not want to do activities. An activity/interest assessment was never completed and should have been within five days after admission. A review of Resident 47's activities care plan indicated, Resident has little to no involvement in activities . Resident wishes to not participate in any activities . An interview was conducted on 8/15/25 at 11:25 A.M. with the administrator (ADM) and the Consultant. The consultant stated, Our activities program needs enrichment and we should have assessed her more thoroughly. A review of the facility's policy, dated 3/2019, titled, Activities Program, indicated, Policy .It is the policy of this facility to implement an ongoing resident centered activities program that incorporated the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental and psychosocial well-being and independence .Procedures:1. Activities are planned according to the residents' preferences,needs and abilities. Every resident will be interviewed for preferences .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36765 Based on observation, interview, and record review, the facility did not ensure a resident with a past trauma received trauma informed care in accordance with professional standards of practice in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of one residents (42) reviewed for trauma informed care. As a result, there was the potential for the resident to not have a sense of emotional and physical safety. Findings: Resident 42 was admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD- a condition in which a person has difficulty recovering after witnessing or experiencing a terrifying event) according to the facility's Admission Record. A concurrent observation and interview was conducted on 8/12/24 at 3 P.M. with Resident 42. Resident 42 was reclining in his bed, watching TV. Resident 42 only wanted to discuss the weather. A review of Resident 42's care plan was reviewed on 8/13/24 at 8:30 A.M. The care plan, titled PTSD, indicated, .Resident is at risk for re-traumatization R/T diagnosis of Post Traumatic Stress Disorder (PTSD); Resident is unable to identify triggers . An interview was conducted on 8/13/24 at 3:24 P.M. with the Assistant Director of Nursing (ADON). The ADON stated, We have been unable to identify his triggers. An interview was conducted on 8/14/24 at 8:40 A.M. with certified nursing assistant (CNA) 21. CNA 21 stated, I don't know his (Resident 42) triggers. An interview was conducted on 8/14/24 at 8:43 A.M. with Registered Nurse (RN) 22. RN 22 stated, I don't know his (Resident 42) triggers, but we should know so we can help avoid them or deal with them. An interview was conducted on 8/14/24 at 8: 50 A.M. with the Director of Staff Development (DSD). The DSD stated, His (Resident 42) triggers are not known to us, but we should try to find out. An interview was conducted on 8/15/24 at 11:41 A.M. with the Administrator (Adm) and the consultant. The consultant stated, The resident and his family can't tell us his triggers, so we should have explored the diagnosis and the triggers more; the care plan is inadequate. A review of the facility's policy, dated 12/2023, titled Behavioral Health Services, indicated, .Policy: It is the policy of this facility to provide residents with necessary behavioral care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being .trauma survivors will receive culturally competent, trauma-informed cared in accordance with professional standards of practice and accounting for residents experiences and preferences in order to eliminate triggers that may cause re-traumatization of the resident .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of four licensed nurses (LN) 10 was competent (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully) to perform medication administration. As result, the medications LN 10 administered to Resident 43 did not consistently adhere to the physician's order, were incompletely given, had hold parameters that were not verified, medications were left unattended, acceptable infection control standards were not implemented, and documentation in the medication administration record (MAR) was inaccurate. These deficiencies had the potential to effect resident safety and the efficacy of treatment. Cross reference F759, F761, F842, and F880. Findings: A review of Resident 43's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness) affecting right side following a stroke, hypertension, dementia (memory loss), and gastrostomy (opening into the abdominal wall for insertion of a feeding tube [g-tube]). On 8/14/24 at 9:03 A.M., a medication administration was observed with LN 10 while at the LN's medication cart located outside of Resident 43's room. LN 10 stated he needed to go find a disinfecting wipe and proceeded to walk down the hallway and out of sight. LN 10 left the medication cart unlocked and unattended. LN 10 returned to the medication cart at 9:05 A.M., and acknowledged the medication cart was unlocked. LN 10 stated he should have locked the medication cart before he left. LN 10 began to dispense Resident 43's medications into individual, unlabeled medication cups (30 milliliters/ml size) as followed: 1. Amlodipine 2.5 milligrams (mg- a unit of measurement) (controls blood pressure [LN 10 crushed the tablet into a powder]) 2. Apixaban 5 mg (anticoagulant [LN 10 crushed the tablet into a powder]) 3. Lactulose 25 ml (promotes bowel movement) 4. Keppra 5 ml (controls seizures) 5. Polyethylene glycol 17 grams (promotes bowel movement [LN 10 mixed it with approximately 4 ounces of water]) 6. Multivitamins 5 ml (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Vitamin D 50 mcg (LN 10 crushed the tablets into a powder). At 9:12 A.M., LN 10 donned personal protective equipment (PPE, gown and gloves) and entered Resident 43's room to administer the medications. LN 10 checked the placement of Resident 43's g-tube. While at the resident's bedside, LN 10 poured cold water into the clear plastic medication cups with powered (crushed) tablet/s. The powdered tablet/s in the medication cups did not fully dissolve in the cold water and adhered to the bottom and/or sides of the medication cups. LN 10 administered the medications to the resident. LN 10 threw away one medication cup with a heavy amount of chalky, white substance into the resident's bedside trash can. The medication cup laid on its side in the trash can on top of the used PPE. LN 10 administered the remaining medications and did not flush the medication cups with water to ensure all the residual medication had been administered. All medication cups had visible residue in them. LN 10 stated he was finished administering Resident 43's medications and disconnected and closed the resident's g-tube. LN 10 retrieved the medication cup that was thrown in the trash can with heavy, white substance and observed it. LN 10 acknowledged that nearly a full dose of medication had remained in the medication cup. LN 10 then stated he would try to administer it again to Resident 43. LN 10 began to reassemble his supplies and to access the resident's g-tube. LN 10 was requested by this surveyor to stop the administration and to not give the resident the medication that had been in the trash can. LN 10 then stated he would not want to be given a medication that had been in the trash can if he were the resident. LN 10 stated it was an infection control concern. LN 10 stated he would go get another dose of medication to give to the resident. LN 10 stated the medication was Amlodipine. LN 10 was asked how he had determined the medication was Amlodipine when there were two medications that had also been crushed into a white powder and placed in unlabeled medication cups. LN 10 stated he knew it was Amlodipine due to the way he had arranged the medication cups. LN 10 went back to the medication cart in the hallway and redispensed Amlodipine 2.5 mg and returned to Resident 43's bedside at 9:30 A.M. The medication mostly dissolved when the cold water was added to the medication cup and became a cloudy mixture. LN 10 observed the mixture in the medication cup and then stated it did not look the same as the chalky, white substance in the previously discarded medication cup. LN 10 then stated the chalky, white substance had been Vitamin D. LN 10 left the cup with the Amlodipine mixture at Resident 43's bedside and returned to the medication cart in the hallway. Resident 43's privacy curtain was drawn and the resident along with the Amlodipine could not be seen by LN 10. LN 10 redispensed Vitamin D 50 mcg and returned to the bedside. At 9:35 A.M., LN 10 administered the Vitamin D to Resident 43. LN 10 was asked if the Amlodipine in the medication cup should have been left unattended at the resident's bedside. LN 10 stated he should not have done that. LN 10 stated the other two residents in Resident 43's room were cognitively impaired and one of them could get out of bed. (continued on next page)

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	08/15/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 9:52 A.M., a joint interview and record review was conducted with LN 10. Resident 43's clinical record was reviewed. Resident 43's physician order for Amlodipine 2.5 mg indicated a hold parameter if the resident's systolic blood pressure was less than 110 mm/Hg (millimeters of mercury, how blood pressure was measured) and/or the resident's heart rate was less than 60 beats per minute. LN 10 was asked how he had verified Resident 43's systolic blood pressure and heart rate when dispensing and administering the resident's Amlodipine. LN 10 stated the certified nursing assistants took the residents' vital signs earlier and wrote them down on a piece of paper and gave it to the charge nurse. LN 10 stated the charge nurse then imputed all the resident's vitals signs into the electronic medical record (EMR). LN 10 navigated the EMR to the vitals record. Resident 43 had a recorded blood pressure of 154/87 mm/Hg and heart rate of 98 beats per minute. This data had an electronic timestamp: 8/14/24 at 9:13 A.M. LN 10 was asked how he knew it was safe to administer Resident 43's Amlodipine when the resident's blood pressure and heart rate were not entered until 9:13 A.M. LN 10 was informed he was already in the process of administering the resident's medications before 9:13 A.M. LN 10 did not provide an answer. LN 10 stated he did not recall receiving any training related to administering medications via g-tube. LN 10 stated he did not recall being evaluated for competency in administering medications via g-tube. On 8/14/24 at 10:05 A.M., an interview was conducted with the director of nursing (DON). The observed medication administration with LN 10 was discussed. The DON stated the medication cart should have been locked when unattended by the LN. The DON stated medications should not have been left unattended at any resident's bedside. The DON was informed that LN 10 had been stopped from giving medication that had been put in the trash can. The DON stated it was unacceptable to administer medication that had been in the trash can. The DON stated LN 10 should have verified the hold parameter for Amlodipine and Resident 43's vital signs before dispensing and administering the medication. The DON stated LN 10 did not administer Resident 43's medications in a competent manner. On 8/14/24 at 11 A.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated she sometimes conducted LN competency evaluations. LN 10's observed medication administration was discussed with the DSD. The DSD stated since LN 10 did not label the medication cups and there was more than one medication crushed into white powder form, he should have stopped and called the physician and informed them of the error. The DSD stated it was not safe to attempt to readminister the unknown medication. The DSD stated it there was the possibility Resident 43 would receive a double dose of medication which could effect the resident negatively. The DSD stated LN 10's medication administration had not been competently done. A review of LN 10's [facility name] Orientation and Annual Skills Checklist Licensed Nurses, dated 3/14/24, indicated, .g. Medication Administration via feeding tube It had an evaluator's initial next to it and a check mark. The DSD stated the initials on LN 10's Orientation and Annual Skills Checklist Licensed Nurses belonged to the DON. On 8/14/24, Resident 43's physician's orders were reviewed, and the resident was ordered to receive 30 ml of Lactulose. Resident 43's medication administration record (MAR) indicated a lactobacillus capsule had been documented as given to the resident during the medication administration observation. This had not been observed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 2:40 P. M., an interview was conducted with LN 10. LN 10 stated Resident 43's Lactulose should have been 30 ml and not 25 ml. LN 10 stated he did not administer Lactobacillus to Resident 43 and had charted in error. LN 10 then stated it had been discussed in the morning meeting that the order for Resident 43's Lactobacillus was going to be discontinued. LN 10 acknowledged the order was still active and that he should have administered the Lactobacillus to Resident 43. A review of the facility's policy titled Nursing Staff Competency, revised 2/2019, indicated, .The competency in skills and techniques necessary to care for residents' needs include but not limited to . G. Medication management .I. Infection Control A review of the facility's undated policy titled Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed .6. The following information must be checked/verified for each resident prior to administering medications .b. Vital signs, if necessary . 14. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse A review of the facility's policy titled Medication Administration- Enteral, dated 1/2024, indicated, It is the policy of this facility to accurately prepare, administer, and document medications . 5. Dilute crushed meds with water

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39111 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 8.33 percent. Three (3) medication errors were observed, a total of 36 opportunities, during the medication administration process for two (2) of five randomly observed residents (Residents 10 and 43). As a result, the facility could not ensure medications were correctly administered to all residents. Cross reference F726. Findings: On 8/14/24 at 9:05 A.M., a medication administration was observed with LN 10. LN 10 began to dispense Resident 43's medications into individual, unlabeled medication cups (30 milliliters/ml size), including but not limited to: Lactulose 25 ml (promotes bowel movement) Vitamin D 50 micrograms (mcg) (LN 10 crushed the tablets into a powder). At 9:12 A.M., LN 10 donned personal protective equipment (PPE, gown and gloves) and entered Resident 43's room to administer the medications. LN 10 checked the placement of Resident 43's g-tube (tube surgically inserted through the abdominal wall for medications and liquid feeding). While at the resident's bedside, LN 10 poured cold water into the clear plastic medication cups with powered (crushed) tablet/s. The powdered tablet/s in the medication cups did not fully dissolve in the cold water and adhered to the bottom and/or sides of the medication cups. LN 10 administered the medications to the resident. LN 10 threw away one medication cup with a heavy amount of chalky, white substance into the resident's bedside trash can. LN 10 stated he was finished administering Resident 43's medications and disconnected and closed the resident's g-tube. LN 10 retrieved the medication cup that was thrown in the trash can with heavy, white substance and observed it. LN 10 acknowledged that nearly a full dose of medication had remained in the medication cup. LN 10 stated the chalky, white substance had been Vitamin D. On 8/14/24 at 9:47 A.M., a medication administration was observed with LN 10. LN 10 began to dispense Resident 10's medications, including but not limited to: Calcium 600 mg plus D 400 International Units (IU- a unit of measurement). Resident 43's physician's orders were reviewed, and the resident was ordered to receive 30 ml of Lactulose and 50 mcg of vitamin D every morning. Resident 10's physician's orders were reviewed and the resident was ordered to receive Calcium 600 mg plus D 200 IU every morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 2:40 P. M., an interview was conducted with LN 10. LN 10 stated Resident 43's Lactulose should have been 30 ml and not 25 ml. LN 10 stated he used the facility supply of Calcium 600 mg plus D 400 IU. LN 10 stated the facility supply contained 200 IU more vitamin D than was ordered for Resident 10. LN 10 stated the physician's orders had not been followed. On 8/14/24 at 10:05 A.M., an interview was conducted with the director of nursing (DON). The observed medication administrations with LN 10 were discussed. The DON stated it was her expectation for the physician's orders to be followed when medications were administered to residents. A review of the facility's undated policy titled Administering Medications, indicated, Medications shall be administered in a safe and timely manner, and as prescribed

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 39220 Based on observation, interview and record review, the facility failed to ensure medications were safely stored when: 1. The medication refrigerator temperature log was incomplete. 2. A food product was found stored in a medication cart. 3. A discontinued medication was not discarded from a medication cart. 4. A medication cart was not locked and unsecured. 5. A medication was left unattended at a resident's bedside. As a result, refrigerator medications could have been ineffective if not stored at the correct temperature, food could cause cross contamination to medications, discontinued medication could have been accidentally been administered, and unauthorized residents, visitors and staff could have access to medications, which could be harmful. Findings: 1. An observation, interview, and record review of the facility's medication room was conducted with the Assistant Director of Nursing (ADON) on 8/15/24 at 8:21 A.M. The refrigerator daily temperature log had missing entries for the day shift (7 A.M. to 3:30 P.M.) on 8/13/24 and 8/14/24. The ADON stated with no documentation of the temperature on those days, the medications inside the refrigerator might not have been stored properly and the medication could be ineffective. An interview was conducted with the Nurse Clinical Consultant 1 (NCC 1) on 8/15/24 at 11:16 A.M., since the Director of Nursing was unavailable. The NCC 1 stated medication refrigerator temperature logs were important to guarantee medications were being stored at the proper temperature. The NCC 1 stated she expected the licensed nurses to check and complete the temperature logs daily. According to the facility's policy, titled Medication Access and Storage, undated, .9. Medications requiring refrigeration or temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit) are kept in the refrigerator with a thermometer to allow temperature monitoring . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An observation and interview was conducted with LN 32 on 8/15/24 at 8:36 A.M., of Station 2's, medication cart #B. During an inspection of medication cart B, a food item was found in the top right medication drawer, located in the front right corner. The food item was brown, caramel-like and wrapped in clear plastic wrapper and twisted at both ends. The size of the food item was approximately 1 inch by 3 inches in size. The wrapper was labeled J Honey, which LN 32 identified as Mexican candy. LN 32 stated she saw the candy there when she took over the cart and should have removed it, but she did not. LN 32 did not know who the candy belonged to or how long it had been stored in the medication cart. An interview was conducted with LN 33 on 8/15/24 at 9 A.M. LN 33 stated candy or food should never be left in a medication cart, because the food and medication could become cross contaminated. An interview was conducted with the Nurse Clinical Consultant 1 (NCC 1) on 8/15/24 at 11:16 A.M., since the Director of Nursing was unavailable. The NCC 1 stated food should never be stored in the medication carts, because of the possibility of cross contamination. According to the facility's policy, titled Medication Access and Storage, undated, .12. Medication storage areas are kept clean, well lit, and free of clutter. 3. An observation and interview was conducted with LN 33 on 8/15/24 at 8:57 A.M., of Station 3's medication cart #B. Inside the top right drawer, an opened medication bottle for Resident 106 labeled Biktavy 30 milligrams (mg)/120 mg/15 mg (a medication used to treat human immunodeficiency virus-HIV) was found. Next to that bottle, was an additional opened medication for Resident 106, labeled Biktavy 50 mg/200 mg/25 mg. LN 33 stated when Resident 106 returned from the hospital, the Biktavy medication dose was increased. LN 33 stated the old bottle of Biktavy 30 mg/120 mg/15 mg, should have been removed from the medication cart when the new medication dose was added. LN 33 stated the patient could have been administered the incorrect, lower dose by accident. On 8/15/24, Resident 106's clinical record was reviewed. According to the physician's order the new Biktavy dose of 50 mg/200 mg/25 mg was added on 8/7/24, and the previous dose of Biktavy 30 mg/120 mg/15 mg was discontinued on 8/7/24. An interview was conducted with the Nurse Clinical Consultant 1 (NCC 1) on 8/15/24 at 11:16 A.M., since the Director of Nursing was unavailable. The NCC 1 stated all discontinued medication should be removed from the medication cart, because it could be administered accidentally. The facility's policy titled Medication Access and Storage, undated, did not give direction to staff for medications discontinued. 47466 39111 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 8/14/24 at 9:03 A.M., a medication administration was observed with LN 10 while at the LN's medication cart located outside of a resident's room. LN 10 stated he needed to go find a disinfecting wipe and proceeded to walk down the hallway and out of sight. LN 10 left the medication cart unlocked and unattended. LN 10 returned to the medication cart at 9:05 A.M., and acknowledged the medication cart was unlocked. LN 10 stated he should have locked the medication cart before he left. On 8/14/24 at 10:05 A.M., an interview was conducted with the director of nursing (DON). The observed medication administration with LN 10 was discussed. The DON stated the medication cart should have been locked when unattended by the LN. A review of the facility's undated policy titled Administering Medications, indicated, .14. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse 5. On 8/14/24 at 9:03 A.M., a medication administration was observed with LN 10. LN 10 was to administer medications to Resident 43. After LN 10 administered Resident 43's medications via g-tube (a tube surgically inserted through the abdominal wall for purposed of medication administration and liquid feeding), LN 10 went back to the medications cart in the hallway and redispensed Amlodipine 2.5 mg (blood pressure medication), crushed the tablet, and mixed it with water in a small medication cup. LN 10 returned to Resident 43's bedside at 9:30 A.M. LN 10 determined Amlodipine was the incorrect medication to readminister. LN 10 left the Amlodipine mixture in the medication cup at Resident 43's bedside and returned to the medication cart in the hallway. Resident 43's privacy curtain was drawn and the resident along with the Amlodipine could not be seen by LN 10. LN 10 redispensed Vitamin D 50 mcg and returned to the bedside. At 9:35 A.M., LN 10 administered the Vitamin D to Resident 43. LN 10 was asked if the Amlodipine in the medication cup should have been left unattended at the resident's bedside. LN 10 stated he should not have done that. LN 10 stated the other two residents in Resident 43's room were cognitively impaired and one of them could get out of bed. On 8/14/24 at 10:05 A.M., an interview was conducted with the director of nursing (DON). The observed medication administration with LN 10 was discussed. The DON stated medications should not have been left unattended at any resident's bedside. A review of the facility's undated policy titled Medication Access and Storage, indicated, It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nurse personnel

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of 29 sampled residents (Resident 122) received food and drink that was palatable, appetizing, and attractive, when the resident was served nectar thick beverages (liquids that had a thickener added to make the consistency like nectar) and some pureed food items (food blended to a pudding-like texture) without a physician's order or clear indication. As a result, Resident 122 stated she did not want to eat the food which put the resident at risk for unintended weight loss and malnutrition. Findings: A review of Resident 122's Admission Record indicated the resident was admitted to the facility on [DATE]. On 8/12/24 at 11:18 A.M., an observation and interview was conducted with Resident 122 while inside the resident's room. Resident 122 stated she did not have teeth and that her teeth had got stolen on the street. Resident 122 was observed with missing teeth. Resident 122 stated she had to eat a pureed diet since being here and it was terrible. Resident 122 stated her food often resembled cat food. Resident 122 stated she was still hungry after food had been served. On 8/12/24 at 1 P.M., an observation of Resident 122's lunch was conducted with the resident. Resident 122 was served an approximately six inch long sandwich resembling a sub with ground meat in it, there was a pureed item on the plate with an orange tinge to it, and a pureed white item that was in a cup. There was a glass of thickened light, brown liquid and a glass of thickened orange liquid. Resident 122 stated she could not tell what the pureed foods were but they tasted bland. Resident 122 stated she could chew the sandwich and was going to cut it into smaller pieces first. Resident 122 stated the drinks served were too thick and she was going to water them down with the water from her pitcher. Resident 122 was observed to have a pitcher of water at her bedside that contained normal, thin water. A review of Resident 122's physician orders dated 7/18/24, indicated, Fortified diet mechanical soft-ground texture, thin liquids consistency for malnutrition. A review of the facility's Summer Menus dated 8/12/24, indicated a resident on the mechanical soft diet was to receive: French Dip-Roast Beef on a Soft Sandwich Roll ground and moistened with broth, soft sweet potato fries, and corn coleslaw chopped to 1/2 inch pieces. On 8/13/24 at 12:57 P.M., an observation of Resident 122's lunch meal was conducted. Resident 122 was served: Peas and onions, garlic rice, two slices of bread, ground meat with gravy covering it. There was a glass of thickened light brown liquid and a glass of thickened white liquid. Resident 122's meal ticket on the food tray indicated, .Fortified .M/S [mechanical soft] ground, thin liquids .Beverages: Nectar thick 4 oz milk, 8 oz juice (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Summer Menus dated 8/13/24, indicated a resident on the mechanical soft diet was to receive: Ground curry lemon chicken with sauce, garlic rice, peas with onions, and wheat roll. On 8/15/24 at 9:35 A.M., a joint interview and record review was conducted with the facility's registered dietitian (RD). The RD reviewed Resident 122's clinical record and stated the resident had no diagnosis of dysphagia (difficulty swallowing) or any other swallowing issues. The RD stated she did not understand why Resident 122 had received pureed food items and nectar thick beverages and that this was confusing. The RD stated Resident 122's nutritional assessment done on 7/17/24 did not review food texture or beverage consistency as that would have been done by the speech therapist. On 8/15/24 at 10:17 A.M., a joint interview and record review was conducted with the RD and the speech therapist (ST). The ST reviewed Resident 122's clinical record and stated the resident was not being seen by therapy and had not been evaluated by ST. The ST stated the director of rehab did an initial screening of the resident on 7/17/24, but the screening did not focus on speech-related issues or diet textures. On 8/15/24 at 11:07 A.M., an interview was conducted with the RD and ST. Both the RD and ST stated Resident 122 should have been receiving a mechanical soft diet, not pureed or with nectar thick beverages. Both stated a resident assessment would need to be conducted. On 8/15/24 at 12:25 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 122's diet texture and fluid consistency should have been clearly understood. The DON stated the resident should not have received pureed food and nectar thick beverages, which the resident did not like, without a clear indication. The DON stated Resident 122 should have received food and beverages that were palatable. A review of the facility's policy titled 483.60 Food and Nutrition Services revised 12/2023, did not provide guidance related to food palatability, food texture, or beverage consistency.

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	055182	A. Building B. Wing	08/15/2024

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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 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 observation, interview, and record review, the facility failed to ensure documentation of medication administration was accurate in one of five residents' (Resident 43) medication administration record (MAR). This failure had the potential to not accurately reflect the treatments provided to residents. Findings: A review of Resident 43's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness) affecting right side following a stroke, hypertension, dementia (memory loss), and gastrostomy (opening into the abdominal wall for insertion of a feeding tube [g-tube]). On 8/14/24 at 9:03 A.M., a medication administration was observed with LN 10. LN 10 began to dispense Resident 43's medications into individual, unlabeled medication cups (30 milliliters/ml size) as followed: 1. Amlodipine 2.5 mg (controls blood pressure [LN 10 crushed the tablet into a powder]) 2. Apixaban 5 mg (anticoagulant [LN 10 crushed the tablet into a powder]) 3. Lactulose 25 ml (promotes bowel movement) 4. Keppra 5 ml (controls seizures) 5. Polyethylene glycol 17 grams (promotes bowel movement [LN 10 mixed it with approximately 4 ounces of water]) 6. Multivitamins 5 ml 7. Vitamin D 50 micrograms (mcg) (LN 10 crushed the tablets into a powder). At 9:12 A.M., LN 10 administered Resident 43's medications and then stated he was finished administering Resident 43's medications and disconnected and closed the resident's g-tube. On 8/14/24, Resident 43's physician's orders were reviewed, and the resident was ordered to receive a Lactobacillus capsule in the morning. Resident 43's medication administration record (MAR) indicated a lactobacillus capsule had been documented as given to the resident during the medication administration observation. This had not been observed. (continued on next page)

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	08/15/2024

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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 2:40 P. M., an interview was conducted with LN 10. LN 10 stated he did not administer Lactobacillus to Resident 43 and had charted in error. LN 10 then stated it had been discussed in the morning meeting that the order for Resident 43's Lactobacillus was going to be discontinued. LN 10 acknowledged the order was still active and that he should have administered the Lactobacillus to Resident 43. On 8/14/24 at 3:25 P.M., an interview was conducted with the director of nursing. The DON stated it was her expectation that documentation in the clinical record accurately reflect the care and/or treatment that was provided. A review of the facility's policy titled Medication Administration- Enteral, dated 1/2024, indicated, It is the policy of this facility to accurately prepare, administer, and document medications

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure one of five residents' (Resident 43) medication administration followed acceptable infection control practices when licensed nurse (LN) 10 attempted to administer a medication that had been disposed of in the trash can. This deficient practice had the potential to expose Resident 43 to infection via the resident's g-tube (a tube surgically placed through the abdominal wall for medication administration and liquid feeding). Cross reference F726. Findings: A review of Resident 43's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness) affecting right side following a stroke, hypertension, dementia (memory loss), and gastrostomy (opening into the abdominal wall for insertion of a feeding tube [g-tube]). A review of Resident 43's physician orders dated 4/11/24, indicated, Enhanced Barrier Precautions: [interventions used to control transmission of microorganisms resistant to antibiotics] PPE [personal protection equipment such as gowns and gloves] required for high resident contact care activities. Indication: Implanted feeding device [g-tube]. On 8/14/24 at 9:03 A.M., a medication administration was observed with LN 10. LN 10 began to dispense Resident 43's medications. At 9:12 A.M., LN 10 donned PPE and entered Resident 43's room to administer the medications. LN 10 checked the placement of Resident 43's g-tube. While at the resident's bedside, LN 10 poured cold water into the clear plastic medication cups with powdered (crushed) tablet/s. The powdered tablet/s in the medication cups did not fully dissolve in the cold water and adhered to the bottom and/or sides of the medication cups. LN 10 administered the medications to the resident. LN 10 threw away one medication cup with a heavy amount of chalky, white substance into the resident's bedside trash can. The medication cup laid on its side in the trash can on top of the used PPE. LN 10 stated he was finished administering Resident 43's medications and disconnected and closed the resident's g-tube. LN 10 retrieved the medication cup that was thrown in the trash can with heavy, white substance and observed it. LN 10 acknowledged that nearly a full dose of medication had remained in the medication cup. LN 10 then stated he would try to administer it again to Resident 43. LN 10 began to reassemble his supplies and to access the resident's g-tube. LN 10 was requested by this surveyor to stop the administration and to not give the resident the medication that had been in the trash can. LN 10 then stated he would not want to be given a medication that had been in the trash can if he were the resident. LN 10 stated it was an infection control concern. LN 10 stated he would go get another dose of medication to give to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 10:05 A.M., an interview was conducted with the director of nursing (DON). The observed medication administration with LN 10 was discussed. The DON was informed that LN 10 had been stopped from giving medication that had been put in the trash can. The DON stated it was unacceptable to administer medication that had been in the trash can. On 8/14/24 at 4 P.M., an interview was conducted with the infection prevention nurse (IPN). The observed medication administration with LN 10 was discussed. The IPN stated attempting to administer a medication that had been in the trash can was not following acceptable infection control practices. The IPN stated no one should ever give a resident a medication that had been in the trash can. The IPN stated Resident 43 also had a g-tube and infection could be spread through the resident's g-tube. A review of the facility's undated policy titled Administering Medications, indicated, Medications shall be administered in a safe and timely manner