

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/18/2025
NAME OF PROVIDER OR SUPPLIER Villa Serena Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 9th Street Long Beach, CA 90813	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview and record review, the facility's interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together) failed to ensure one of one resident (Resident 41) was assessed to determine if the resident was capable of self-administering medications.</p> <p>This deficient practice had the potential for Resident 41 to self-administer medications incorrectly resulting in subtherapeutic (below the level necessary to treat effectively) medication effects which can lead to health issues.</p> <p>Findings:</p> <p>During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was originally admitted to the facility on [DATE] with diagnoses including allergic rhinitis (inflammation [redness and swelling] of the inside of the nose) and asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways which makes it harder to breathe).</p> <p>During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool), dated 8/13/2024, the MDS indicated Resident 41's cognition was intact. The MDS indicated Resident 41 needed set up assistance with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 41's Physician Order Report: active orders as of 1/15/2025, the report indicated the following:</p> <ol style="list-style-type: none"> 1) Ordered 8/21/2024, Artificial Tears ophthalmic solution (eye drops to treat dry eyes) instill one drop in both eyes four times a day. 2) Ordered 8/21/2024, Fluticasone Salmeterol Inhalation aerosol powder breath activated (medication to treat asthma) 250-50 micrograms/ actuation (unit of measure) 3) Ordered 8/21/2024, Ipratropium Bromide Nasal Solution 0.03 percent (medication to treat allergic rhinitis), 2 spray each nostril three times a day. 4) Sodium chloride nasal solution 0.65% (salt mixed with water used to rinse sinuses) 1 spray both nostrils two times a day. <p>(continued on next page)</p>

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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 1/14/2025 at 8:12 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 41 was observed self-administering artificial tears, Fluticasone Salmeterol Inhalation aerosol powder, Ipratropium Bromide Nasal Solution, Sodium chloride nasal solution 0.65% in front of LVN 2. LVN 2 confirmed and stated Resident 41 had capacity, was very independent, and have been self-administering eye drops, nasal sprays, and inhaler daily.</p> <p>During an interview and record review on 1/15/2025 at 1:19 p.m., with Registered Nurse Supervisor (RN) 1, Resident 41's medical records were reviewed and indicated Resident 41 did not have an order to self-administer medications and the IDT did not assess Resident 41 if the resident was able to self-administer medications. RN 1 stated Resident 41 needed an order to self-administer medications, and the IDT team need to assess Resident 41 if the resident can self-administer medications.</p> <p>During an interview with the Director of Nursing (DON) on 1/17/2025 at 6:10 p.m., the DON stated a resident may self-administer medications only if physician ordered and if the resident was assessed by the IDT team that they can administer their own medication.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication - Self-Administration, revised 2/9/2024, the P&P indicated, Residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team and physician has determined that the practice would be safe for the resident and the result of the assessment are recorded in the resident's medical record.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to ensure the residents' medical records were updated to show documentation that a resident has an advance directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for one of three sampled residents (Resident 42).</p> <p>This deficient had the potential to cause conflict with the residents' wishes regarding health care.</p> <p>During a review of Resident 42's Admission record, the Admission record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (MDD: a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), and hypertension (high blood pressure).</p> <p>During a review of Resident 42's History and Physical (H&P) dated 9/18/2024, the H&P indicated Resident 42 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 42's Minimum Data Set (MDS a resident screening tool), dated 12/20/2024, the MDS indicated Resident 42's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were intact. The MDS indicated Resident 42 required supervision for toilet transfer and bathing, required set up for toilet hygiene, chair/bed to chair transfer, dressing the lower body (below waist), and was independent on all other aspects of activities of daily living (ADL: eating, oral hygiene, personal hygiene). The MDS indicated Resident 42 utilized a wheelchair and a walker and did not have any impairments on both the upper (arms/shoulders) and lower extremities (hip/legs).</p> <p>During a review of Resident 42's Advance Directive Acknowledgement dated 9/20/2024, the advance directive acknowledgement indicated Resident 42 had an advance directive currently in place.</p> <p>During an interview on 1/15/2025 at 12:41 p.m., with the Social Service Director (SSD), the SSD stated an Advance Directive is a document that indicates if they want to assign a representative to make medical decisions in case they do not have the capacity to make decisions for themselves. The SSD stated she is responsible for the Advance Directives and upon admission, the admitting nurse provides an Advance Directive form to the resident and the SSD will follow up with the Resident. The SSD stated if the resident already has an advance directive, she will reach out to the family to ensure they provide the document as soon as possible (within 48 to 72 hours).</p> <p>During a concurrent interview and record review on 1/5/2025 at 12:46 p.m. with the SSD Resident 42's medical records were reviewed. The SSD stated when Resident 42 was admitted , she discussed the Advance Directive with Resident 42's family but had not received a copy of the Advance Directive. The SSD stated Resident 42's Advance Directive was not in Resident 42's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policies and Procedures (P&P), titled Advance Directives, dated February 9, 2024, the P&P indicated upon admission, the admission staff or designee will obtain a copy of a resident's advance directive. A copy of the resident's advance directive will be included in the resident's medical record.</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to protect the Resident's right to be free from neglect when licensed nurses did not provide needed services to prevent the resident, who had difficulty breathing, from becoming unresponsive and die for one of one sampled resident (Resident 45).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure licensed nurses conducted timely assessments of Resident 45's physical condition when the resident developed breathing difficulty. 2. Ensure Licensed Vocational Nurse (LVN) 1 had Resident 45 vital signs (measurements of the body's basic functions including oxygen saturation [amount of oxygen in blood], blood pressure [force of blood pushing against the blood vessels walls in the heart], respiration [process of breathing in and out], heart rate (pulse : number of times the heart beats per minute), and temperature (measure how well the body can make and get rid of heat) taken and monitored when Certified Nursing Assistant (CNA 1) notified LVN 1 on [DATE] at 11:10 p.m., that the resident was having difficulty breathing. 3. Ensure Registered Nurse (RN) 1 monitored Resident 45's condition when she noted Resident 45 was having out of range oxygen saturation level (measure of how much oxygen is in the blood cells. For residents with Chronic Obstructive Pulmonary [referencing to lungs] disease ([COPD] a progressive lung disease that causes difficulty breathing) the reference range is 88% to 92%) on room air and was weak. 4. Ensure RN 1 notified Resident 45's physician of the resident's weakness and refusal to wear a LifeVest (a wearable device that help treat heart failure by monitoring for abnormal heart rhythms and deliver a shock to restore normal rhythm) upon admission. 5. Ensure staff followed the facility's policy and procedures (P&P) titled, Abuse Prevention and Prohibition Program, dated February 9, 2024, which indicated residents would be protected from neglect. <p>These deficient practices resulted in Resident 45 not being monitored by the licensed nurses when Resident 45 had difficulty breathing and weakness on [DATE] at 11:10 p.m. On [DATE] at 4:26 a.m., Resident 45 was found unresponsive and was pronounced dead at 5:07 a.m., by the Paramedics (emergency medical response staff).</p> <p>These deficient practices placed 48 residents in the facility at risk to be neglected by licensed nurses in case their condition was changed.</p> <p>On [DATE] at 6:55p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and the Director of Nursing (DON).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:57 p.m., the ADM submitted an acceptable IJ removal plan ([IJRP], an intervention to immediately correct the deficient practices). After verification of the IJRP implementation through observation, interview, and record reviews, the IJ was removed on [DATE] at 5:50p.m. in the presence of the ADM and the DON.</p> <p>The IJRP included the following:</p> <ol style="list-style-type: none"> 1. Resident 45 expired on [DATE]. 2. On [DATE], the DON provided RN 1 with a one-to-one in-service (education) regarding responsibilities of a licensed nurse when assessment findings are outside the normal range. The in-service emphasized the importance of monitoring and reassessing the resident to determine the effectiveness of interventions and the resident's response to the interventions. 3. On [DATE], at 8:34 p.m., LVN 1 was sent home on an administrative leave pending the results of the facility's investigation of the allegation. 4. The facility has 48 residents in-house. All residents have the potential to be affected by the same deficient practice. 5. On [DATE], the DON reviewed changes in condition that occurred in the last 24 hours to ensure that the residents were assessed timely and appropriately. There were four residents with changes in condition. Licensed nurses assessed the residents timely and appropriately. 6. On [DATE] and [DATE] the Administrator and Director of Staff Development (DSD) provided an in-service to 47 facility's employees (62.6% of the total staff) regarding the facility's policy on Abuse and Neglect Prohibition. The in-service emphasized the following: <ol style="list-style-type: none"> a. Different types of abuse, including neglect. b. The definition and examples of neglect. c. The responsibility of the staff to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 7. The facility staff were given a post-test at the end of the in-service to evaluate their knowledge of the information they received. Passing score is 6 out of 6. Staff who don't pass will be asked to attend the in-service and take the post-test again. Staff who are currently on vacation or on leave (three licensed nurses) will be provided the in-service and post-test upon their return to work. 8. All new hires will be provided with an in-service and post-test by the Director of Staff Development (DSD) regarding the facility's policy on Abuse and Neglect Prohibition. Staff who don't pass will be asked to attend the in-service and take the post-test again. The in-service will address the following: a) Different types of abuse, including neglect; b) The definition and examples of neglect; c) The responsibility of the staff to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>9. Starting [DATE], the Administrator or designee will provide Abuse and Neglect Prevention in-service to staff quarterly for 1 year and twice a year thereafter.</p> <p>10. On [DATE], the DON and Nurse Consultant provided an in-service to three RNs (100% of facility RNs) and 10 LVNs (76.9% of facility LVNs) regarding managing changes of condition. The in-service emphasized the following points: a) Conducting timely assessments, including vital signs, of a resident who has a change in condition; b) Notifying the physician of changes in condition; c) Monitoring the resident's condition; d) Reassessing the resident to determine the resident's response and the effectiveness of the interventions.</p> <p>11. The licensed nurses were given a post-test at the end of the in-service to evaluate their knowledge of the information they received. Passing score is 5 out of 5. Licensed nurses who don't pass will be asked to attend the in-service and take the post-test again. Staff who are currently on vacation or on leave (three licensed nurses) will be provided the in-service and post-test upon their return to work.</p> <p>12. Starting [DATE], the DON will provide training on managing changes in condition for all newly hired licensed nurses.</p> <p>13. The DON will review changes in condition daily, from Monday through Friday, to ensure that prompt resident assessment was conducted in response to the change in condition. Changes in condition that occur on the weekend will be reviewed the following Monday. Findings will be corrected immediately.</p> <p>14. The Medical Records Director will audit changes in condition daily, from Monday through Friday, to ensure that the medical provider was notified of changes in condition. Changes in condition that occur on the weekend will be audited the following Monday. Findings will be reported to the DON for follow-up.</p> <p>15. The DSD will report the number of new hires for the month and if the abuse in-service training was provided for them to the Quality Assessment and Assurance ([QAA] process to identify how the facility is performing and maintain quality of care) Committee during the Quality Assurance Performance improvement ([QAPI] process to improve services and outcomes) meeting monthly for three months.</p> <p>16. The DON will report findings and trends from the change in condition review to the QAA Committee during the QAPI meeting monthly for three months.</p> <p>17. The Medical Records Director will report findings and trends from the change in condition audits to the QAA Committee during the QAPI meeting monthly for three months.</p> <p>Findings:</p> <p>During a review of Resident 45's Admission record, the Admission Record indicated Resident 45 was initially admitted to the facility on [DATE] and was readmitted from a general acute care hospital (GACH) on [DATE] with diagnoses including COPD, End Stage Renal Disease ([ESRD] irreversible kidney failure), Congestive Heart Failure ([CHF] a disorder which causes the heart not to pump blood efficiently, sometimes resulting in leg swelling), and Type II Diabetes Mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 45's History and Physical (H&P) dated [DATE], the H&P indicated Resident 45 had fluctuating (varied) capacity to understand and make decisions. The H&P indicated Resident 45 was a full code (resident chooses to receive all life saving measures in case of an emergency) status.</p> <p>During a review of Resident 45's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 45's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were mildly impaired. The MDS indicated Resident 45 required moderate assistance for most of her activities of daily living (sit to stand, chair/bed to chair transfer, walking 10 feet, shower transfer, dressing, bathing, oral and toileting hygiene), required supervision (no physical assistance) for personal hygiene, and required set up for eating. The MDS indicated Resident 45 utilized a wheelchair and did not have any impairments on both upper (arms/shoulders) and lower extremities (hip/legs).</p> <p>During a review of Resident 45's Order Summary Report (Physician's orders), the Order Summary Report indicated an order dated [DATE] to monitor the resident's vital signs every shift for 72 hours (every shift for baseline vital signs for three days).</p> <p>During a review of the Nurses Progress Notes dated [DATE] and timed at 7:25 a.m., completed by LVN 1, the Nurses Progress Notes indicated that on [DATE] around 2:20 a.m., Resident 45 was resting and was responsive to verbal stimuli (sounds or words produced by a speaker to get attention) with no complications. The Nurses Progress Notes indicated at 4:25 a.m., Resident 45 was unresponsive even after a Sternal Rub (painful stimulus with the knuckles at the center of the chest) to the center of the chest, so Cardiopulmonary Resuscitation (CPR an emergency procedure to restart a person's heart [chest compressions] and breathing after one or both have stopped) was initiated, 911 was called, and the doctor was notified. The Nurses Progress Notes indicated at 4:41a.m., Paramedics arrived at the facility and took over Resident 45's CPR. The Nurses Progress Notes indicated at 5:07a.m., Paramedics pronounced Resident 45 deceased .</p> <p>During a review of the Nurses Progress Notes dated [DATE] at 8:49 p.m., documented by RN 1, the Nurses Progress Notes indicated Resident 45 was alert and oriented, her respirations were even and unlabored (easy, effortless breathing, without any signs of difficulty or struggle), her blood pressure was ,d+[DATE] millimeters of mercury ([mmHg] unit of measure. Reference range ,d+[DATE] mmHg), heart rate of 80 beats per minute (reference range 60 to 100), respiratory rate of 17 breath per minute (reference range 12 to 20 breaths per minute), and 94% oxygen saturation on 3.0 ([L]unit of measure) per minute (min) L/M through a nasal cannula ([NC] device that delivers oxygen through thin tube s placed into nostrils). RN 1 stated she was uncomfortable with the way Resident 45 presented as she (Resident 45) seemed being out of it. RN 1 stated Resident 45 was too weak to sign the admission documents and the Physician Orders for Life-Sustaining Treatment ([POLST]residents' preferences for medical treatment) and said she would do it tomorrow on [DATE]. RN 1 stated when a resident is newly admitted or readmitted , the nurse that admits the resident completes a head-to-toe assessment, reviews the residents' medications and notifies the admitting physician for admission orders. RN 1 stated Resident 45 came to the facility with her LifeVest but she was not wearing it. RN 1 stated the nurse, who gave report over the phone from the GACH, told her Resident 45 refused the LifeVest. RN 1 stated when Resident 45 was admitted she did not look right. RN 1 stated she relayed this information to LVN 1 to ensure LVN 1 would monitor Resident 45 closely. RN 1 stated she should have informed the doctor that Resident 45 was not doing well upon admission. RN 1 stated the interventions to implement when a resident found unresponsive and pulseless (no heartbeat) include the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE], at 9:15 a.m., CNA 1, stated on [DATE] at 11:10 p.m., she notified LVN 1 that Resident 45 was gasping for air and did not look well. CNA 1 stated she went to Resident 45's room with LVN 1. CNA 1 stated she did not witness LVN 1 assessing the resident or taking Resident 45 vital signs. CNA 1 stated LVN 1 told her he would go and look in Resident 45's chart. CNA 1 stated she went to check on Resident 45 again between 4:00 a.m. and 4:05 a.m., and she was still breathing. CNA 1 stated she went back to Resident 45's room around 4:26 a.m., when she heard LVN 1 in Resident 45's room calling Resident 45's name out loud four times. CNA 1 stated LVN 1 told her that Resident 45 was unresponsive, and they did not need to do anything. CNA 1 stated LVN 1 told her we do not need to check Resident 45's vitals. CNA 1 stated she still went to get the vital signs machine and asked CNA 2, who was in the hallway, to join her to assist. CNA 1 stated when CNA 2 and her went back into Resident 45's room with the vitals machine, LVN 1 instructed CNA 2 and her (CNA 1) to start CPR. CNA 1 stated when they started CPR Resident 45 was cold to the touch on her face, hands, and legs. CNA 1 stated LVN 1 brought in the crash cart, did not provide oxygen rescue breaths to Resident 45 during CPR, did not take the vital signs, and did not place the Back Board under Resident 45. CNA 1 stated she did not witness LVN 1 perform CPR on Resident 45 at any time. CNA 1 stated LVN 1 stated he was going to call the Paramedics and did not return to Resident 45's room after that. CNA 1 stated she and CNA 2 took turns to do Resident 45's chest compressions, but they did not provide any rescue breaths as they did not have an Ambu-Bag (handheld device to provide respiratory support to patients who are not breathing). CNA 1 stated while CNA 2 was doing chest compressions, she heard the Paramedics entering the facility and she instructed CNA 2 to stop doing chest compressions since the Paramedics were in the building.</p> <p>During an interview on [DATE], at 10:07 a.m., CNA 2 stated when he was going to take the trash out after changing a resident, he saw CNA 1 walking towards him. CNA 2 stated he did not know what was going on as he did not hear any Code Blue called. CNA 2 stated he walked with CNA 1 to Resident 45's room per CNA 1's request and observed Resident 45 laying in bed with the head of bed elevated. CNA 2 stated CNA 1 asked LVN 1 if he wanted to take vitals and he said, no it is fine and instructed him and CNA 1 to begin CPR, as he (LVN 1) left the room to call Paramedics. CNA 2 stated CNA 1 was looking out in the hallway and heard the Paramedics were coming so she told him (CNA 2) to stop doing chest compressions. CNA 2 stated Paramedics came in and took over the situation. CNA 2 stated at the beginning of the shift (11:00 p.m. to 7:00 a.m.), CNA 1 notified him (CNA 2) that Resident 45 did not look well so CNA 1 and him went to observe Resident 45 together. CNA 2 stated upon observation, Resident 45 had the oxygen via nasal cannula on, but seemed weak as she was not able to move her arms or change positions in her bed and appeared to have issues with breathing.</p> <p>During a concurrent interview and record review on [DATE] at 1:47 p.m., with RN 1, Resident 45's Medication Administration Record ([MAR] document that tracks medications given to residents) dated [DATE] - [DATE] was reviewed. RN 1 stated there were no vital signs documented but considering Resident 45's history of COPD, the oxygen saturation should have been checked and documented. RN 1 stated a review of the doctor's order indicated to monitor vital signs every shift for 72 hours (every shift for baseline vital signs for three days) on [DATE]. RN1 stated since Resident 45's vital signs were not taken; the doctors' orders were not followed. RN 1 stated if it was not documented it was not done. RN 1 stated doctors' orders have to be followed, not following the orders can compromise the residents' health.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:32 p.m., the DSD stated if a Code Blue is called, someone gets supplies, check oxygen saturation, have someone documenting the vital signs, get the crash cart, and call 911. The DSD stated the blood pressure cuff will not be taken off and the vital signs will be continuously checked. The DSD stated every resident's vital signs should be checked at the beginning of the shift. The DSD stated there is a nonrebreather (a manual device used to deliver oxygen) mask on the crash cart, and a Back Board that is needed to provide effective chest compressions. The DSD stated during a Code Blue, while one staff is performing chest compressions another staff member gives rescue breaths with the Ambu-Bag. The DSD stated someone calls the code blue on the overhead paging system to ensure everyone in the facility is aware of the emergency and can respond immediately. The DSD stated CPR needs to be continuous until there is a pulse or until Paramedics arrive and take over the CPR.</p> <p>During an interview on [DATE] at 3:21p.m., the DON stated if a resident is nonresponsive the most important body systems to assess are airways (a passage where air reaches a person's lungs), breathing, and blood circulation. The DON stated if it is appropriate, to start chest compressions, have someone call 911, bring the crash cart, use the Ambu-Bag for rescue breaths. The DON stated chest compressions will be continuously provided until the Paramedics will arrive and take over.</p> <p>During an interview on [DATE] at 4:22 p.m., the DON, stated when a new admission or readmission arrives at the facility, the licensed nurse should accompany the resident to the room to observe the resident's condition and ensure the resident is stable. The DON stated when a resident has a change in condition (COC) the licensed staff are expected to check the resident's blood sugar level and vital signs to see if they are within normal reference range. The DON stated when a resident is having shortness of breath, the licensed nurse cannot leave the resident unmonitored until the resident's condition is stable.</p> <p>During a concurrent interview and record review on [DATE] at 4:42 p.m., LVN 1's Progress Notes were reviewed. The DON stated Resident 45 was admitted back to the facility on [DATE] and passed at the facility on [DATE]. The DON stated the vital signs should have been taken within the shift 11 p.m. to 7 a.m. The DON stated the vital signs were not recorded and if it was not documented it was not done. The DON stated LVN 1 and/or RN 1 did not check Resident 45's blood sugar level since Resident 45 was a diabetic and was unresponsive. The DON stated the licensed nurses did not check Resident 45's vital signs during 11:00 p.m. to 7:00 a.m. shift and the last vital signs were taken on [DATE] at 8:49 p.m. during the resident's admission. The DON stated there were no documentations to indicate whether LVN 1 checked Resident 45's pulse prior to instructing CNA 1 and CNA 2 to start CPR. The DON stated when CNA 1 reported to LVN 1 that Resident 45 was not doing well, LVN 1 should have assessed Resident 45 immediately when he went to the resident's room and to check vital signs.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on [DATE] at 4:53 p.m., with the DON, Resident 45's the Cardiology (a department responsible for concerns with diagnosis and treatment of heart-related diseases and disorders) Note and Supportive Care and Palliative (care focused on improving quality of life for individuals with serious illness without curing the condition) Visit Notes from the GACH were reviewed. The DON stated the Cardiology Note dated [DATE], indicated Resident 45 had a risk for sudden cardiac arrest (an unexpected condition where the heart stops breathing). The DON stated since Resident 45 refused the LifeVest and further implantable cardioverter defibrillator (ICD) small device that monitors and responds to abnormal heart rhythm), Resident 45 was a high risk for cardiac arrest without interventions from the LifeVest or the ICD. The DON stated the Supportive Care and Palliative Visit Note from the GACH indicated Resident 45 wanted CPR. The DON stated when a resident has a Full Code status, the CPR is expected to be initiated when a resident unresponsive.</p> <p>During a concurrent interview and record review on [DATE] at 5:13 p.m., with the Emergency Medical Services Captain (EMSC), the Paramedic Run Sheet dated [DATE] was reviewed. The EMSC stated when the Paramedics arrived on scene, Resident 45 was found lying on her back in bed pulseless and apneic (involuntarily and temporarily stopped breathing). The EMSC stated the facility's staff were not doing CPR when they arrived. The EMSC stated initiating CPR may increase the chances of a resident survival.</p> <p>During an interview on [DATE] at 6:28 p.m., the DON stated neglect constitutes when staff does not provide needed care and staff is not doing their job in such instances if a resident needs medication and it is not given, that would be considered negligence.</p> <p>During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, dated February 9, 2024, the P&P indicated each resident has the right to be free from neglect, and mistreatment. The facility has zero-tolerance for neglect, staff must not permit anyone to engage in neglect, and mistreatment. The facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met. Neglect: inadequate provision of care, caregiver indifference to resident's personal care and needs.</p> <p>During a review of the facility's P&P, titled, Change of Condition Notification, dated February 9, 2024, the P&P indicated an acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavior, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. The Licensed Nurse will assess the resident's change of condition and document the observations and symptoms. A Licensed Nurse will document the following: Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. A Licensed Nurse will document each shift for at least seventy-two (72) hours.</p> <p>During a review of the facility's P&P, titled, Admission Assessment, dated February 9, 2024, the P&P indicated the assessment process must include direct and indirect observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. Assessment findings may necessitate communication with attending physician for treatment or care orders. The assessment will be documented and will be communicated with licensed and nonlicensed direct care staff members on all shifts.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P, titled, Cardiopulmonary Resuscitation, dated February 21, 2024, the P&P indicated to sustain or support a resident's cardiac and/or pulmonary function(s) until medical emergency personnel are available to take over the resuscitation efforts. Cardiopulmonary resuscitation is instituted on all residents except those designated as No Code or No CPR. In the absence of a DNR order, CPR will be performed. The facility will perform CPR in accordance with the guideline set forth by the American Heart Association. Establish unresponsiveness, verify code status prior to the initiation of CPR, alert the emergency response team (call 911), check for pulse, CPR will be initiated using the standards outline in the American Heart Association's most current CPR guidance, continue CPR until paramedics arrive and take over.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to ensure two of four sampled residents' (Residents 39 and Resident 44) Preadmission Screening and Resident Review (PASRR) assessment screening was reassessed to determine the facility's ability to provide the special needs of the residents.</p> <p>This deficient practice placed the residents at risk of not receiving necessary care and services they need.</p> <p>a. During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including major depressive disorder (MDD a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (group of mental health conditions characterized by fear, nervousness, and excessive worry), and post-traumatic stress disorder (PTSD: mental health condition that develops after experiencing or witnessing traumatic events).</p> <p>During a review of Resident 39's History and Physical (H&P) dated 6/14/2024, the H&P indicated Resident 39 had the capacity to understand and make decisions.</p> <p>During a review of Resident 39's Minimum Data Set [MDS a resident assessment tool], dated 12/19/2024, the MDS indicated Resident 39's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were intact. The MDS indicated Resident 39 is dependent for chair/bed-to-chair transfer, bathing, dressing lower body (below hip), and required maximal assistance (able to provide less than half the effort) for eating and performing oral, toilet, and personal hygiene. The MDS indicated Resident 39 utilized a wheelchair and walker for mobility.</p> <p>During a review of Resident 39's PASRR Level I screening dated 6/12/2024, the section that indicated whether an individual has a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, psychosis, and or mood disturbance, the PASRR indicated Resident 39 did not have a serious mental illness.</p> <p>During an interview on 1/14/2025 at 2:37 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated upon admission, the resident will come with a PASRR, and if there is a change of condition (COC), the facility will initiate a new PASRR. The MDSC stated the Director of Nursing (DON), Medical Records (MR), and the Business Office (BO) have access to the PASRR. The MDSD stated when there is a COC, the DON is responsible to initiate a new PASRR.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review of the PASRR on 1/14/2025 at 2:41 p.m., with MDSC, the MDSC stated Resident 39 has a diagnosis (dx) of depression, anxiety, and PTSD. The MDSC stated on the PASRR Level I screening document in section III Serious Mental Illness-Definition: Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder ., it is documented as Resident 39 does not have a serious mental illness, but it is not correct as per dx, Resident 39 has a diagnosis of depressive disorder. The MDSC stated the PASRR is important to identify whether a resident may require a follow up as it may affect the way they provide care for the resident.</p> <p>b. During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) with current episode manic without psychotic features, alcohol abuse (drinking alcohol in a harmful way or when dependent on alcohol), and adult failure to thrive (decline in health and ability for older individuals).</p> <p>During a review of Resident 44's History and Physical (H&P) dated 11/10/2024, the H&P indicated Resident 44 has the capacity to understand and make decisions.</p> <p>During a review of Resident 44's MDS, dated [DATE], the MDS indicated Resident 44's cognitive skills were mildly impaired. The MDS indicated Resident 44 is dependent for shower transfers, required moderate assistance (assists with less than half the effort) for bathing, chair/bed-to-chair transfer, lower body dressing, and required supervision for personal, toileting, and oral hygiene, dressing the upper body (above waist), and required set up for eating. The MDS indicated Resident 44 utilized a walker for mobility and does not have any impairments on both the upper (shoulders/arms) and lower extremities (hip, legs). The MDS indicated Resident 44 had little interest or pleasure in doing things and feeling down, depressed, or hopeless for several days (two to six days).</p> <p>During a review of Resident 44's PASRR Level I screening dated 11/8/2024, in the section to indicate an individual has a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, psychosis, and or mood disturbance, the PASRR indicated Resident 44 did not have a serious mental illness.</p> <p>During a concurrent interview and record review of the PASRR on 1/14/2025 at 2:54p.m. with the MDSC, the MDSC stated Resident 44 has a dx of failure to thrive, bipolar, and alcohol abuse. The MDSD stated in section III Serious Mental Illness-Definition: Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder .or symptoms of psychosis, delusions, and/or mood disturbance, it does not indicate bipolar. The MDSD stated Resident 44 was receiving Lithium Carbonate (treat manic-depressive disorder (bipolar disorder) oral capsule 300miligram (mg: a unit of mass) by mouth two times a day related to bipolar disorder, current episode manic without psychotic features unspecified (manifested by (m/b) recurrent behavior fluctuations from depressed behaviors to manic behavior and vice versa every shift) and indicated the PASRR Level I screening is not filled out properly and may indicate the residents are not getting the care they need.</p> <p>During a review of the facility's policy and procedure (P&P), titled Pre-Admission Screening and Resident Review (PASRR), dated February 9,2024, the P&P indicated the purpose is to ensure that all Facility applicants are screened for mental illness and/or intellectual disability.</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to ensure the resident, who had a Full Code (resident wants all life saving measures in case of emergencies) status and was in distress received Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart (chest compressions) to increase the chances of a resident's survival for one of 39 residents who had a Full Code status (Resident 45).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure facility staff were knowledgeable what actions to take when responding to a resident in distress. 2. Ensure Licensed Vocational Nurse (LVN)1 announced a Code Blue (an announcement that signifies a medical emergency where a patient is experiencing a life-threatening situation) when he found Resident 45 unresponsive. 3. Ensure LVN 1 provided resuscitation (action or process of reviving someone from unconsciousness or apparent death) and basic life support ([BLS], basic care healthcare professionals provide to anyone who's heart stops beating suddenly) such as CPR, immediately without loss of critical time to Resident 45 when the resident was found unresponsive (a person is unable to respond to their surrounding and do not react to stimulation like touch, sound, or pain) on [DATE] at 4:30 p.m. 4. Ensure Certified Nursing Assistant (CNA) 1 and CNA 2 did not stop delivering chest compressions (involves giving strong, rapid pushes to the chest to keep blood moving through the body) to Resident 45's before the Paramedics were able to take Resident 45's CPR over. 5. Ensure staff implemented the facility's policy and procedure (P&P) titled, Cardiopulmonary Resuscitation dated February 21, 2024, which indicated to sustain or support a resident's cardiac (related to heart) and/or pulmonary (related to lungs) function(s) until medical emergency personnel are available to take over the resuscitation efforts and the American Heart Association ([AHA] the leader in resuscitation science, education, and training, and publisher of the official Guidelines for CPR) guidelines that indicated First responder would call for help, send available staff to call a Code Blue and retrieve emergency medical equipment, assess the residents' level of consciousness, circulation, airway, and breathing and begin CPR, call 911, CPR will continue until the paramedics arrive and assume responsibility. <p>These deficient practices resulted in the delay of life saving measures such as CPR for Resident 45 when she was found unresponsive on [DATE] at 4:30 p.m., and pronounced dead on [DATE] at 5:07 a.m. These deficient practices placed 38 residents, who had a Full Code status at risk not to receive CPR.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 6:55 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure the facility staff provided basic life support to Resident 45, including CPR immediately upon discovering the resident had difficulty breathing and became unresponsive.</p> <p>On [DATE] at 2:57 p.m., the Facility submitted an acceptable IJ removal plan ([IJRP], an intervention to immediately correct the deficient practices). After verification the IJRP was implemented through observation, interview, and record reviews, the IJ was removed while onsite on [DATE] at 5:50 p.m., in the presence of the ADM and the DON.</p> <p>The IJRP included the following:</p> <ol style="list-style-type: none"> 1. Thirty eight of the 48 residents in the facility were Full Code. All 38 residents have the potential to be affected by the same deficient practice. There were no medical emergencies that occurred in the last 24 hours. 2. On [DATE], a BLS certified instructor provided BLS training to 11 licensed nurses (91.6% of total licensed staff) and 18 CNAs (64.2%). The training consisted of in person instructions on when to initiate CPR and how to perform the CPR correctly according to the American Heart Association guidelines, and skills demonstration of the proper CPR procedure. 3. On [DATE], the DON and the Nurse Consultant conducted a Code Blue drill for nursing staff to simulate a medical emergency. The drill emphasized the staff's responsibility to respond to a medical emergencies, the various roles and responsibilities of the staff when responding to a medical emergency, how to operate emergency equipment found in the crash cart (cart stocked with emergency medical equipment, supplies, and drugs for use by medical personnel especially during efforts to resuscitate a patient experiencing cardiac arrest), including the Ambu-bag (a medical device that helps patients breathe by forcing air into their lungs) and cardiac board (a rigid board used to provide a firm surface for chest compressions during CPR). There were 12 licensed nurses (92.3% of total number of licensed nurses) and 18 CNAs (64.2%) who participated in the drill. Nursing staff who were currently on vacation or on leave will be provided the in-service and post-test upon their return to work. 4. Starting [DATE], the DON and Nurse Consultant will conduct a Code Blue drill for nursing staff quarterly for one year and then annually thereafter. 5. On [DATE], the DON and Nurse Consultant provided an in-service to three Registered Nurses (RNs) (100%) and 10 LVNs (76.9%) regarding managing changes of condition. The in-service emphasized the following points: <ol style="list-style-type: none"> a. Conducting timely assessments, including vital signs, of a resident who has a change in condition. b. Notifying the physician of changes in condition. c. Monitoring the resident's condition. <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>d. Reassessing the resident to determine the resident's response and the effectiveness of the interventions.</p> <p>e. Initiating CPR promptly when the resident is not breathing and/or does not have a pulse.</p> <p>f. The licensed nurses were given a post-test at the end of the in-service to evaluate their knowledge of the information they received. Passing score was 5 out of 5. Licensed nurses who don't pass will be asked to attend the in-service and take the post-test again. Staff who are currently on vacation or on leave (three licensed nurses) will be provided the in-service and post-test upon their return to work.</p> <p>g. The DON will review changes in condition daily, from Monday through Friday, to ensure that prompt resident assessment was conducted in response to the change in condition. Changes in condition that occur on the weekend will be reviewed the following Monday. Findings will be corrected immediately.</p> <p>h. The DON will report findings and trends from the change in condition review to the Quality Assessment and Assurance ([QAA] process to identify how the facility is performing and maintain quality of care) Committee during the Quality Assurance Performance improvement ([QAPI] process to improve services and outcomes) meeting monthly for three months.</p> <p>i. The Medical Records Director will report findings and trends from the change in condition audits to the QAA Committee during the QAPI meeting monthly for 3 months.</p> <p>Findings:</p> <p>During a review of Resident 45's Admission record, the Admission Record indicated Resident 45 was initially admitted to the facility on [DATE] and was readmitted from a general acute hospital (GACH) on [DATE] with diagnoses including Chronic Obstructive Pulmonary disease (COPD: progressive lung disease causing difficulty in breathing), End Stage Renal Disease (ESRD: irreversible kidney failure), Congestive Heart Failure (CHF: a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and Type II Diabetes Mellitus (DM: a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 45's History and Physical (H&P) dated [DATE], the H&P indicated Resident 45 had fluctuating (varied) capacity to understand and make decisions. The H&P indicated Resident 45 was a Full Code (FC) status.</p> <p>During a review of Resident 45's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 45's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were mildly impaired. The MDS indicated Resident 45 required moderate assistance for most of her activities of daily living (sit to stand, chair/bed to chair transfer, walking 10 feet, shower transfer, dressing, bathing, oral and toileting hygiene), required supervision (no physical assistance) for personal hygiene, and required set up for eating. The MDS indicated Resident 45 utilized a wheelchair and did not have any impairments on both the upper (arms/shoulders) and lower extremities (hip/legs).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Villa Serena Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 9th Street Long Beach, CA 90813	
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 45's Order Summary Report (physician's orders), the Order Summary Report indicated an order dated [DATE] to monitor the resident's vital signs (measurements of the body's basic functions including oxygen saturation [amount of oxygen in blood], blood pressure [force of blood pushing against the blood vessels walls in the heart], respiration [process of breathing in and out], heart rate (pulse : number of times the heart beats per minute), and temperature (measure how well the body can make and get rid of heat) every shift for 72 hours (every shift for baseline vital signs for three days).</p> <p>During a review of the Paramedics (emergency medical responders) report dated [DATE] at 4:45 a.m., the Paramedics report indicated when the Paramedics arrived to Resident 45's room, Resident 45 was lying on her back, pulseless (no heart beat), apneic (involuntarily and temporarily stops breathing), had an oxygen saturation (amount of oxygen in blood) of 79 percent (%) (COPD resident reference rate 88% to 92%), and a blood glucose (amount of sugar in blood) level of 45 (reference range 70 milligrams per deciliter (mg/dL: unit of measure used to report concentration of a substance in a fluid) to 100mg/dL). The Paramedics report indicated the staff did not conduct CPR prior to the Paramedics arrival. The report indicated the Paramedics initiated CPR at 4:45a.m., and after 20 minutes of performing CPR with no change, Resident 45 was pronounced dead at 5:07 a.m.</p> <p>During a review of the Nursing Admission assessment dated [DATE] at 8:43 p.m., the Nursing Admission Assessment indicated Resident 45 was admitted on [DATE] at 6:55p.m. Resident 45 was alert, oriented to person, had weakness in both upper and lower extremities.</p> <p>During a review of the Nurses Progress Notes dated [DATE] at 7:25 a.m., documented by LVN 1, the Nurses Progress Notes indicated around 2:20 a.m., Resident 45 was resting and responsive to verbal stimuli (sounds or words produced by a speaker to get attention) with no complications. The Nurses Progress Notes indicated at 4:25a.m., Resident 45 was unresponsive to sternal rub (painful stimulus with the knuckles at the center of the chest), CPR was initiated, 911 was called, and the doctor was notified. The Nurses Progress Notes indicated at 4:41 a.m., Paramedics arrived at the facility and took over Resident 45's CPR. The Nurses Progress Notes indicated at 5:07a.m., Paramedics pronounced Resident 45 deceased .</p> <p>During an interview on [DATE] at 2:32p.m., RN 1 stated when Resident 45 arrived at the facility on [DATE], she appeared unkempt, speech was clear and seemed tired. RN 1 stated during Resident 45's admission assessment, Resident 45 was able to state her name, her oxygen saturation (measure of how much oxygen is in the blood cells [COPD resident reference rate 88% to 92%]) was in the low 90s. so she gave the resident oxygen at 3.0 liters ([L] unit of measure) per minute (min) via nasal canula ([NC] device that delivers oxygen through a very small thin tubes placed into each nostril). RN 1 stated she was uncomfortable with the way Resident 45 presented because she seemed out of it. RN 1 stated Resident 45 was too weak to sign admission documents or the Physician Orders for Life-Sustaining Treatment ([POLST] residents' preferences for medical treatment) and indicated she would do it tomorrow. RN 1 stated at the end of her shift she gave report to LVN 1 (the incoming nurse) to monitor Resident 45. RN 1 stated Resident 45 came to the facility with her LifeVest (a wearable device to monitor for abnormal heart rhythms and deliver a shock to restore normal rhythm) but she was not wearing it. RN 1 stated 1. RN 1 stated when Resident 45 was admitted , she did not look right.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 3:55p.m., LVN 1 stated he worked on [DATE] during the night shift (11p.m. to 7 a.m.). LVN 1 stated when he came to work, he made rounds and visually checked on all the residents, to see if the residents were breathing. LVN 1 stated he received report from the outgoing RN 1 read Resident 45's H&P and continued to provide care to other residents after he observed Resident 45 at 2:20 a.m. was doing okay. LVN 1 stated he normally makes rounds every one to two hours. LVN 1 stated around 4:00 a.m., he noticed Resident 45 was not communicating and unresponsive. LVN 1 stated Resident 45 was laying down and was warm to the touch. LVN 1 stated he initiated CPR, went to call 911, and had to go back to continue CPR. LVN 1 stated CNA 1 and CNA 2 were in Resident 45's room to help with CPR while he called 911. LVN 1 stated CNA 1 and CNA 2 took turns to do CPR. LVN 1 stated Resident 45 was wearing her nasal canula and he placed the flat board (provide a firm surface when chest compressions are performed to provide adequate and effective compressions) underneath the resident.</p> <p>During an interview on [DATE], at 9:15 a.m., CNA 1, stated she went to check on Resident 45 between 4:00 a.m. and 4:05 a.m., and the resident was breathing. CNA 1 stated she went back to Resident 45's room around 4:26 a.m., when she heard LVN 1 calling Resident 45's name out loud four times. CNA 1 stated LVN 1 told her that Resident 45 was unresponsive. CNA 1 stated LVN 1 to her nothing needed to be done, and she did not need to check Resident 45's vital signs. CNA 1 stated she still went to get the vital signs machine and asked CNA 2, who was in the hallway, to join her to assist. CNA 1 stated when CNA 2 and her went back into Resident 45's room with the vitals machine, LVN 1 instructed CNA 2 and her (CNA 1) to start CPR. CNA 1 stated when they started CPR, Resident 45 was cold to the touch on her face, hands, and legs. CNA 1 stated LVN 1 brought in the crash cart. CNA 1 stated no one provided rescue breaths to Resident 45 during CPR, no one took her vital signs and no one placed a Back Board under Resident 45. CNA 1 stated she did not witness LVN 1 perform CPR on Resident 45 at any time. CNA 1 stated LVN 1 stated he was going to call the Paramedics and never came back to Resident 45's room after that. CNA 1 stated she and CNA 2 took turns doing compressions, but they did not provide any rescue breaths as they did not have an Ambu-bag. CNA 1 stated while CNA 2 was doing compressions, she heard the Paramedics entering the facility and she instructed CNA 2 to stop doing compressions since the Paramedics were in the building.</p> <p>During an interview on [DATE], at 10:07 a.m., CNA 2 stated at the on [DATE] at the beginning of the shift (11:00 p.m. to 7:00 a.m.), CNA 1 notified LVN 1 that Resident 45 did not look-well and they together went to observe Resident 45. CNA 2 stated upon observation Resident 45 had oxygen via nasal cannula, but seemed weak as she was not able to move her arms and could not change positions in bed and appeared to have issues breathing. CNA 2 stated on [DATE], when he was going to take the trash out after changing one of the residents, he saw CNA 1 walking towards him and asked for his help with Resident 45, who was in distress. CNA 2 stated he did not know there was a Code Blue because he did not hear the code to be announced overhead .</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:32 p.m., with the Director of Staff Development (DSD), the DSD stated during any shift, if a resident is in respiratory distress, licensed staff must assess the resident, call the doctor, check vital signs, and to give oxygen if the resident is desaturating (blood oxygen level is dropping). The DSD stated someone will call a Code Blue on the overhead to ensure everyone in the facility is aware and can respond immediately. The DSD stated staff must work together to gather supplies such as the crash cart, check and document the vital signs, and call 911. The DSD stated if a resident has a change of condition staff should take vital signs. The DSD stated an Ambu-bag is on the Crash Cart to provide breaths during compressions. The DSD stated staff should use a Back Board from the Crash Cart to provide effective compressions, if there is no Back Board, then staff need to put the resident on the floor for effective compressions. The DSD stated CPR needs to be continuous until there is a pulse or until the Paramedics arrive and take over.</p> <p>During an interview on [DATE] at 1:56 p.m., CNA 3 stated she worked the 11 p.m. to 7 p.m. shift on [DATE]. CNA 3 stated she did not hear any Code Blues called on [DATE] during the 11:00p.m. to 7:00a.m.</p> <p>During an interview on [DATE] at 3:21 p.m., the DON stated if a resident is nonresponsive the licensed nurses should assess the resident's breathing, heartbeat, and if indicated start chest compressions while another staff member calls 911, bring the Crash Cart, use the Ambu-bag. The DON stated chest compressions should be continuous until the Paramedics come and take CPR over.</p> <p>During a concurrent interview and record review on [DATE] at 4:42 p.m., with the DON, Resident 45's Nurses Progress Notes dated [DATE] were reviewed. The DON stated Resident 45 was admitted back to the facility on [DATE] and passed at the facility on [DATE]. The DON stated the resident's vital signs were not recorded during the 11 p.m. to 7 a.m. shift. The DON stated if it was not documented, it was not done. The DON stated during a life-threatening emergency someone will call a Code Blue on the overhead speaker to ensure everyone in the facility is aware and can respond immediately. The DON stated on [DATE] at 11:10 p.m. when CNA 1 reported to LVN 1 that Resident 45 was having difficulty breathing, LVN 1 should have assessed Resident 45 immediately, including taking vital signs and checking oxygen saturation. The DON stated since Resident 45 was a Full Code, the life saving measures such as CPR should have been initiated immediately when the resident was found unresponsive.</p> <p>During a concurrent interview and record review on [DATE] at 4:53 p.m., with the DON Resident 45's GACH records were reviewed. The DON stated on the Cardiology Note dated [DATE], Resident 45 had a risk for sudden cardiac arrest as she had refused the LifeVest and further implantable cardioverter defibrillator ([ICD] small device that monitors and responds to abnormal heart rhythm) workup.</p> <p>During a concurrent interview and record review on [DATE] at 5:13 p.m., the Paramedic Run Sheet dated [DATE] was reviewed with the Emergency Medical Services Captain (EMSC).The EMSC stated when the Paramedics arrived on scene (Resident 45's bedside), Resident 45 was found pulseless and apneic lying on her back in bed. The EMSC stated staff did not start CPR prior to the Paramedics arrival. The EMSC stated initiating CPR timely may increase the chances of survival of the resident and the facility was not doing CPR when they arrived.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Cardiopulmonary Resuscitation dated February 21, 2024, the P&P indicated to sustain or support a resident's cardiac and/or pulmonary function(s) until medical emergency personnel are available to take over the resuscitation efforts. Cardiopulmonary resuscitation is instituted on all residents except those designated as No Code or No CPR. In the absence of a Do Not Resuscitate ([DNR] medical order that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) order, CPR will be performed. The facility will perform CPR in accordance with the guideline set forth by the American Heart Association. Establish unresponsiveness, verify code status prior to the initiation of CPR, alert the emergency response team (call 911), check for pulse, CPR will be initiated using the standards outline in the American Heart Association's most current CPR guidance, continue CPR until paramedics arrive and take over, Documentation: Whether the incident was witnessed:</p> <p>A. Date and time event was recognized.</p> <p>B. When you found the resident and started CPR.</p> <p>C. Condition of the resident when ventilation (respiration status), chest compressions or defibrillation needed.</p> <p>D. How long the resident received CPR.</p> <p>E. The resident's response to CPR.</p> <p>F. Any interventions taken to correct complications.</p> <p>During a review of the facility's P&P titled, Change of Condition Notification, dated February 9, 2024, the P&P indicated an acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavior, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. The Licensed Nurse will assess the resident's change of condition and document the observations and symptoms. A Licensed Nurse will document the following: Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. A Licensed Nurse will document each shift for at least seventy-two (72) hours.</p> <p>During a review of the facility's P&P titled, Medical Emergencies-Code Blue dated February 9, 2024, the P&P indicated to ensure the prompt and effective response by Facility personnel during medical emergencies through the use of the Code Blue procedure. A medical emergency is defined as one of the following conditions requiring immediate medical intervention and the initiation of the Code Blue procedure: Respiratory or cardiac arrest (when the heart suddenly and unexpectedly stops beating). Once CPR is initiated, it will continue until Paramedics arrive.</p> <p>I. First Responder</p> <p>A. The first of Facility personnel to arrive and find a resident with any of the above conditions will:</p> <p>1. Call for help.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Send available staff to call a Code Blue and retrieve emergency medical equipment.</p> <p>3. Assess the resident's level of consciousness, circulation, airway, and breathing; begin CPR according to the current practice. Note: The first responder should not leave the victim to call for help unless absolutely necessary according to the situation.</p> <p>4. When the second responder arrives, have the second responder place the cardiac arrest board under the resident and assist with two-rescuer CPR.</p> <p>II. Subsequent Responder(s):</p> <p>A. Active the Emergency Response System-Call 911.</p> <p>B. Direct all needed personnel to the Code Blue site.</p> <p>C. Send a Staff member to the entrance door to wait where the ambulance is expected to arrive.</p> <p>D. The first RN to respond will lead the code unless responsibility is transferred to another licensed staff member (RN or Medical Doctor).</p> <p>E. If no other RN or MD is available, the RN will follow the procedure as given in the Unit Nurse or Designee section below.</p> <p>F. Note: One person CPR will be maintained until there is a second responder available to begin two person CPR.</p> <p>G. CPR will continue until the paramedics arrive and assume responsibility.</p> <p>III. Roles During the Code:</p> <p>Any available Nursing Staff will complete the tasks as directed in the First Responder and Subsequent Responder sections of this procedure.</p> <p>IV. Licensed Nurse:</p> <p>A. In the absence of an Attending Physician, it will be the responsibility of the first licensed staff member responding to the code to lead, and coordinate the resuscitation efforts until paramedics arrive.</p> <p>B. The nurse will assure that the following tasks have been completed and/or assigned:</p> <ol style="list-style-type: none"> 1. CPR has been initiated. 2. 911 has been called. 3. Code Blue or STAT (immediately) has been paged overhead. 4. Emergency Cart is on the scene. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 4), who was assessed at a moderate risk for developing a skin injury and had intact skin, did not develop the following:</p> <p>a. Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on the sacrum area (tailbone) measuring 0.5 centimeters [(cm) unit of measurement] in length, 0.5 cm in width and 0 cm in depth on 1/5/2025.</p> <p>b. An open area 0.5 cm round superficial red open area on the right buttocks area on 5/25/2024, resolved (healed) on 6/7/2024.</p> <p>c. Stage II pressure injury on coccyx (tailbone area) measured 1.5 cm length by 1.3 cm in width, and 0.2 cm in depth on 6/21/2024, resolved on 7/16/2024.</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Implement Resident 4's (untitled) care plan intervention to turn and reposition the resident as needed when in bed or the wheelchair, to prevent the resident from developing a pressure injury by relieving the pressure from the sacrum area. 2. Implement the facility's policy and procedure (P&P) titled, Wound Management revised 2/9/2024, that indicated to prevent the development of skin breakdown/pressure injuries to: <ol style="list-style-type: none"> a) minimize pressure on the wound, b) notify the Interdisciplinary Team (IDT) to discuss and recommend new interventions for pressure ulcers that reoccur and about pressure ulcers that do not respond to treatment or worsen. <p>These deficient practices resulted in Resident 4 developing a facility-acquired, preventable, Stage II pressure injury on the sacrum area measuring 0.5 cm in length and 0.5 cm in width on 1/5/2024, an open area on the buttocks area measuring 0.5 cm round in the buttocks area on 5/25/2024, and a Stage II pressure injury on the coccyx on 6/21/2024 measuring 1.5 cm long by 1.3 cm wide by 0.2 cm depth.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), age related osteoporosis (a disease that causes bones to become weak and more likely to break) without current pathological fracture (broken bones), type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and mild protein calorie malnutrition (condition where body does not get enough protein and energy).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's Minimum Data Set ([MDS], a resident assessment tool), dated 12/4/2024, the MDS indicated Resident 4's cognitive skills (ability to think and reason) for daily decision-making were severely impaired. The MDS indicated Resident 4 required partial assistance (helper does less than half the effort helper lifts support or holds trunk or limbs but provides less than half the effort) with personal hygiene, substantial assistance (helper does more than half the effort, helper lifts or hold trunk or limbs and provides more than half the effort) with eating, dressing, and Resident 4 was dependent (helper does all the effort. Resident does none of the effort to complete activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene and rolling left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS indicated Resident 4 was at risk for developing pressure injuries. The MDS indicated Resident 4 did not have pressure ulcers or any unhealed pressure injuries. The MDS indicated Resident 4's skin was intact and did not have any ulcers, wounds, and skin problems. The MDS indicated Resident 4 was NOT on a turning and repositioning program.</p> <p>During a review of Resident 4's Braden Scale (a scoring tool used to predict residents' risk of developing a pressure injury, total scores range from 6 - 23. A lower score indicating a higher risk of developing a pressure injury) assessment, dated 3/6/2024, the Braden Scale assessment indicated Resident 4's score was 13 indicating Resident 4 was at moderate risk for developing a pressure injury. The Braden Scale indicated Resident 4's skin was very moist, the resident was chairfast (capable of maintaining a sitting position but lacking the capacity of bearing own weight), had very limited mobility, was unable to make frequent or significant positional changes independently and required moderate to maximum assistance when moving.</p> <p>During an interview and record review on 1/15/2025 at 10:31 a.m. with Certified Nurse Assistant (CNA) 4 Resident 4's CNA flowsheet for January 2025 there was no documented evidence of Resident 4 being turned and repositioned. CNA 4 stated there was no documentation Resident 4 was turned and repositioned.</p> <p>During an interview and record review on 1/15/2025 at 11:28 a.m., with Treatment Nurse 1 (TX 1) Resident 4's Braden Scale for Predicting Pressure Score Risk, dated 3/6/2024, was reviewed and TX 1 confirmed and stated Resident 4's score was 13 indicating Resident 4 was at moderate risk for developing a pressure injury. The Braden Scale indicated Resident 4's skin was very moist, the resident was chairfast, had very limited mobility, was unable to make frequent or significant positional changes independently and required moderate to maximum assistance when moving.</p> <p>During an interview and record review on 1/15/2025 at 11:30 a.m., with TX 1, Resident 4's Skin Weekly Assessment, dated 3/7/2024, was reviewed and TX 1 confirmed and stated Resident 4' did not have a pressure injury in the buttocks or sacrum and coccyx area.</p> <p>During an interview and record review on 1/15/2025 at 11:31 a.m., with TX 1, Resident 4's SBAR (Situation, Background, Assessment, request) Form and progress note, dated 5/25/2024, was reviewed and TX 1 confirmed and stated Resident 4 developed a 0.5 cm superficial red open area on the right buttocks area.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and record review on 1/15/2025 at 11:33 a.m., with TX 1, Resident 4's Skin Weekly Assessment, dated 6/7/2024, was reviewed and TX 1 confirmed and stated Resident 4 developed a facility acquired 0.5 cm superficial red open area on the right buttocks area on 5/25/2024 and it was resolved on 6/7/2024. TX 1 stated the wound was cleansed daily with normal saline (saltwater solution used to clean wounds) and zinc oxide ointment (medicated cream to treat skin irritations) was applied and covered with a dry dressing (gauze dressing that protects wound and helps it heal).</p> <p>During an interview and record review on 1/15/2025 at 11:36 a.m., with TX 1, Resident 4's SBAR Form and progress note, dated 6/21/2024, was reviewed and TX 1 confirmed and stated Resident 4 developed a Stage II pressure injury in the coccyx area measuring 1.5 cm in length by 1.3 cm in width and 0.2 cm in depth and the physician ordered the wound to be cleansed with normal saline, apply zinc oxide, and cover with dressing daily. TX 1 stated this pressure injury was healed on 7/16/2024.</p> <p>During an interview and record review on 1/15/2025 at 11:40 a.m., with TX 1, Resident 4's SBAR Form and progress note, dated 1/5/2025, was reviewed and TX 1 confirmed and stated Resident 4 developed a Stage II pressure injury in the sacrum area measuring 0.5 cm in length by 0.5 cm in width and 0 cm in depth and the physician ordered the wound to be cleansed with normal saline, apply zinc oxide, and cover with dressing daily. TX 1 stated the IDT should meet to discuss new interventions because this was a pressure ulcer that reoccurred. TX 1 stated there was no documented evidence that Resident 4 was repositioned and turned at least every 2 hours and there should be because if it was not documented it was not done.</p> <p>During an interview and record review on 1/15/2025 at 11:42 a.m., with TX 1, Resident 40's Order Summary report as of 1/15/2025, was reviewed and the summary report indicated the following:</p> <ul style="list-style-type: none"> a. A physician's order dated 10/16/2021, seat cushion while in wheelchair. b. A physician's order dated 3/8/2024, for Multivitamin and minerals (supplement) tablet daily. c. A physician's order dated 3/15/2024, Pro-Stat Oral liquid (supplement liquid protein for wound healing) sugar free, give 30 milliliters one time a day. d. A physicians order dated 6/28/2024 for Ascorbic acid (Vitamin C supplement) 500 milligrams by mouth two times a day e. A physician's order dated 1/6/2025, for Sacrum pressure injury cleanse with normal saline, pat dry, apply zinc oxide and cover with dry dressing daily x 30 days. f. A physician's order dated 1/7/2025, for a low air loss mattress (mattress designed to prevent and treat pressure wounds). g. A physician's order dated 1/19/2025, for Boost (Nutrition powder to promote wound healing) one can two times a day for dietary supplement. <p>TX 1 stated the orders indicated were interventions initiated because of Resident 4's recurring pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 1/16/2025 at 9:35 a.m. with the Treatment Nurse 1 (TX 1) at Resident 4's room, Resident 4 was noted to have a Stage II pressure injury on the coccyx area that had no drainage and was 100% epithelial tissue (light pink tissue) and it measured 1 cm in length and 1.2 cm in width.</p> <p>During a record review of Resident 4's untitled care plan initiated on 1/5/2025, The care plan indicated Resident 4 was at risk for developing pressure injuries related to reduced mobility, impaired cognition, variable oral intake, diabetes, malnutrition, osteoporosis, dementia, and history of pressure injuries. The care plan goal indicated Resident 4's risk for skin breakdown will be minimized through review on 3/4/2025. The care plan interventions included Resident 4 would turn and repositioned as necessary, use turn, or lift sheets with position changes, and encourage resident to turn and reposition changes.</p> <p>During an interview on 1/17/2025 at 6:10 p.m., with the Director of Nursing (DON), the DON stated the facility goal was to prevent pressure ulcer development so, the IDT needs to discuss new interventions if not working. The DON also stated the facility need to turn resident at least every 2 hours to prevent pressure ulcers from developing. The DON stated if it was not documented it was not done.</p> <p>During a review of Pressure Injury Prevention Points Portable Document Format (PDF) published by the National Pressure Injury Prevention Advisory Panel, copyright 2020, the PDF indicated the following pressure injury prevention points:</p> <ol style="list-style-type: none"> 1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. 3. Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. 4. Continue to reposition an individual when placed on any support surface. 5. Reposition weak or immobile individuals in chairs hourly (www.npiap.com) <p>During a review of the facility's P&P titled, Wound Management revised 2/9/2024, the P&P indicated to prevent the development of skin breakdown/pressure injuries to:</p> <ol style="list-style-type: none"> a) minimize pressure on the wound, b) notify the Interdisciplinary Team (IDT) and physician to discuss and recommend new interventions for pressure ulcers that reoccur and about pressure ulcers that do not respond to treatment or worsen. Rehabilitation Services will be notified for appropriate devices and pressure redistributing devices. <p>(continued on next page)</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Pressure Ulcer Prevention, implemented 2/9/2024, the P&P indicated the purpose of the policy was to implement measures to prevent and or manage pressure ulcers and minimize complications. The P&P indicated care, and services will be provided to promote and prevent pressure ulcer development. The P&P indicated the nurse will consult with the IDT - Skin Committee.		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review, the facility failed to ensure one of one hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) resident (Resident 22) received dialysis care and services based on professional standards. The facility failed to:</p> <p>a. Notify the physician, assess Resident 22, educate Resident 22 regarding and risk for missing HD, and monitor Resident 22 for complications after Resident 22 missed HD on 1/2/2025 and 1/3/2025.</p> <p>b. Assess Resident 22 and complete Resident 22's Dialysis Transfer Information (form used by facility and dialysis center to communicate regarding resident status) prior to sending Resident 22 to dialysis on 12/14/2024.</p> <p>These deficient practices had the potential to result in complications from dialysis.</p> <p>Findings:</p> <p>During a review of Resident 22's Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis.</p> <p>During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 22's cognition (ability to think) was moderately impaired. The MDS indicated Resident 22 needed set up assistance when eating and partial assistance (helper does less than half the effort) with oral, personal, and toileting hygiene.</p> <p>During a review of Resident 22's Physician Order Report: active orders as of 1/15/2025, the report indicated, starting 11/1/2024, hemodialysis procedure to an outpatient dialysis center Tuesday, Thursday, and Saturday.</p> <p>During an interview and record review on 1/15/2025 at 2:39 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 22's Dialysis Transfer Information, dated 12/14/2024, and LVN 2 stated the pre assessment section to be completed by the facility was blank indicating it was not completed. LVN 2 stated it should have been filled out for continuity of care.</p> <p>During an interview and record review on 1/15/2025 at 2:39 p.m. with LVN 2, Resident 22's nurse progress notes dated 1/2/2025, LVN 2 stated on 1/2/2025 Resident 22's dialysis was rescheduled by the dialysis center to 1/3/2025 at 1:30 p.m. because the elevators in the dialysis center was not working. Resident 22's nurse progress notes indicated on 1/3/2025 at 3:16 p.m. Resident 22 refused to go to the makeup dialysis session. LVN 2 stated the following were not completed:</p> <p>a. The physician was not notified of Resident 22's refusal and missed HD on 1/2/2025 and 1/3/2025.</p> <p>b. Resident 22 was not assessed for missing 2 days of dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Resident 22 was not monitored for complications like shortness of breath or respiratory distress for refusing dialysis.</p> <p>d. Resident 22 was not educated on risk of refusing dialysis.</p> <p>During an interview on 1/17/2025 at 6:10 p.m. with the Director of Nursing (DON), the DON stated if a dialysis resident refused dialysis the staff need to monitor the resident for complications, assess the resident, and notify the physician of the refusal. The DON stated the facility needs to educate the resident of risk of refusal of hemodialysis. The DON stated staff need to assess the resident before sending resident to dialysis and the staff need to fill up the form to send to the dialysis center for report, so the dialysis center knows what's going on with the resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Dialysis Care revised 7/19/2024, the P&P indicated Residents with ESRD will be cared for. The P&P indicated staff will monitor the resident prior to dialysis treatment and address communications between the dialysis provider and the facility. The P&P indicated the nephrologist and dialysis provider and the residents attending practitioner must be notified of a canceled or postponed dialysis treatment and responses to the change in treatment must be documented in the resident's medical record. If the dialysis is cancelled or postponed the nursing staff dialysis provider should provide or obtain ongoing monitoring and medical management for changes such as fluid gain, respiratory issues, review of relevant lab results, and any other complications that occur until dialysis can be rescheduled based on resident assessment stability and need. If the resident. Does not comply with his care plan. The facility will document this noncompliance with following care plan and make the necessary adjustments, including providing additional education to the resident. If the resident continues to be non-compliant, the Interdisciplinary team (IDT) will meet with the resident and his family to discuss risks and benefits.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview, and record review the facility failed to ensure one of three residents' (Resident 7) Restoril (medication for insomnia - trouble falling or staying asleep) was available.</p> <p>This deficient practice had the potential to result in Resident 7's lack of sleep which can result in negative health outcomes.</p> <p>Findings</p> <p>During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnosis including insomnia.</p> <p>During a review of Resident 7's Minimum Data Set (MDS), a resident assessment tool, dated 11/14/2024, the MDS indicated Resident 7's cognition was intact. The MDS indicated Resident 7 needed set up assistance when eating, performing oral hygiene, and supervision with upper dressing, toileting hygiene, personal hygiene, and showering.</p> <p>During a review of Resident 7's Order Listing Report for Temazepam (Restoril), from 12/1/2024 to 1/31/2025, the summary indicated on 1/11/2025, Restoril 30 milligrams (mg - unit of measure) was discontinued and the dose was decreased to 15 mg once a day at bedtime.</p> <p>During the resident council meeting (gathering of residents and their representatives to discuss concerns, share information, and make decisions), on 1/14/2025 at 2:11p.m., Resident 7 stated she's (Resident 7) been waiting for her medication- Restoril, for a couple of days.</p> <p>During an observation, interview and record review on 1/14/2025 at 2:40 p.m. with Registered Nurse Supervisor (RN)1, RN 1 checked the medication cart and confirmed Resident 7 did not have Restoril 15 milligrams available. RN 1 checked Resident 7's orders on the computer and noted a new order for Restoril 15 milligrams. RN 1 stated, on 1/11/2025, Restoril 15 milligrams should have been available for Resident 7 to help the resident sleep.</p> <p>During an interview on 1/17/2025 at 6:10 p.m., with the Director of Nursing (DON), the DON stated ordered medication should be available for the residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Provider Pharmacy Requirements, effective 4/2008, the P&P indicated regular and reliable pharmaceutical service is available, seven days a week 24 hours per day, to provide residents with prescription medications. Medication orders should be available the same date the medication is ordered.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview and record review the facility failed to ensure:</p> <p>a) One of three sampled resident's (Resident 22) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for psychotropics (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) was obtained.</p> <p>b) Three of six sampled resident's (Resident 22, 41, and 18) were evaluated for a gradual dose reduction (involves the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication) of psychotropic medications.</p> <p>c) One of one sampled resident's (Resident 44) was appropriately being monitored for the signs and symptoms of lithium toxicity (occurs when you have too much of the prescription medication lithium in your body).</p> <p>d) One of one sample resident's (Resident 42) had one of his benign prostatic hyperplasia (BPH: non-cancerous enlargement of the prostate gland (small gland located in male reproductive system) medication was discontinued per pharmacy recommendation.</p> <p>These deficient practices had the potential to result in residents' unnecessary consumption of medications and cause untoward adverse reactions for taking psychotropic medications.</p> <p>Findings:</p> <p>a) During a review of Resident 22's Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 22's cognition was moderately impaired. The MDS indicated Resident 22 needed set up assistance when eating and partial assistance (helper does less than half the effort) with oral, personal, and toileting hygiene.</p> <p>During a review of Resident 22's History and Physical (H&P), dated [DATE], the H&P indicated Resident 22 had the capacity to understand and make decisions.</p> <p>During a review of Resident 22's Physician Order Report: active orders as of [DATE], the report indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1) Ordered [DATE], Ativan (medication to treat anxiety - emotion that can feel like dread or fear, and it can be a normal reaction to stress) 1 mg orally one time a day every Tuesday, Thursday, Saturday prior to leaving the facility for dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed).</p> <p>2) Ordered [DATE], Mirtazapine (medication to treat depression), 15 mg orally at bedtime manifested by poor oral intake.</p> <p>3) Ordered [DATE], Seroquel (medication for bipolar disorder) 25 mg tablet give half a tablet orally two times a day manifested by sudden mood change.</p> <p>During an interview on [DATE] at 2:30 p.m. with Licensed Vocational Nurse (LVN) 2, and record review Resident 22's medical records. Resident 22 did not have consent for Ativan. Resident 22 had a consent for Seroquel and mirtazapine signed by a family member and not by Resident 22. LVN 2 stated the Resident 22 had capacity and should have signed the consents for the medications.</p> <p>b) During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Post traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).</p> <p>During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41's cognition was intact. The MDS indicated Resident 41 needed set up assistance with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 41's Order summary report as of [DATE], the report indicated, on [DATE], Sertraline (medication to treat depression) oral tablet, 100 milligrams (mg - unit of measure), give one tablet once a day, manifested by fatigue and loss of energy and trazadone (medication to treat depression) 50 mg orally at bedtime manifested by inability to sleep.</p> <p>During an interview on [DATE] at 3:02 p.m., with Registered Nurse Supervisor (RN) 1, and record review Resident 41's medical records, it indicated Resident 41 has not had a GDR and was overdue. RN 1 confirmed and stated Resident 41 was taking Sertraline and trazadone and should have been attempted to see if the medications Resident 41 was taking was effective.</p> <p>During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paranoid schizophrenia (a type of schizophrenia (a serious mental health condition that affects how people think and behave) accompanied by obsessive anxiety), major depressive disorder, and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18's cognition was mildly impaired. The MDS indicated Resident 18 required moderate assistance (provide less than half the effort) for chair-bed-to-chair transfer, personally and toileting hygiene, bathing, and lower body dressing (below waist), and required supervision for oral hygiene, eating, and dressing upper body (above waist). The MDS indicated Resident 18 had an impairment one side of the upper extremity (arms/shoulders) and utilized a walker and wheelchair. The MDS indicated Resident 18 had potential indicators of psychosis (condition characterized by a loss of contact with reality) of hallucinations (false perceptions) and delusions (unable to tell from what is real from what is imagined).</p> <p>During a review of Resident 18's H&P dated [DATE], the H&P indicated Resident 18 does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 18's Physician Order Report: active orders as of [DATE], the report indicated the following:</p> <p>1) Ordered [DATE] Abilify oral tablet 2 mg (Aripiprazole: antipsychotic medicine used to treat schizophrenia) 2 mg by mouth two times a day for delusional thoughts manifested by (m/b) calling out to deceased spouse related to paranoid schizophrenia.</p> <p>2) Ordered [DATE] Remeron oral tablet 15mg (Mirtazapine: medication to treat depression) 15mg by mouth at bedtime for poor oral intake, less than 50% of each meal, related to major depressive disorder, recurrent.</p> <p>During a review of the psychotropic and sedative (promoting calm or inducing sleep)/hypnotic utilization by resident dated [DATE] and [DATE], the utilization report indicated Resident 18 had an order for Aripiprazole 2mg twice a day on [DATE] with the last GDR dated [DATE]. Resident 18 had an order for Remeron (Mirtazapine tab 15mg) once a day ordered on [DATE] with last GDR date [DATE] with a next evaluation date of [DATE].</p> <p>During an interview on [DATE] at 6:10 p.m. with the Director of Nursing (DON), the DON stated it was important to attempt a GDR monthly to make sure medications were appropriate and effective. The DON stated all psychotropics need to be administered only after informed consent was obtained because it was the residents' rights.</p> <p>c) During a review of Resident 44's Face Sheet, the Face Sheet indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) with current episode manic without psychotic features, alcohol abuse (drinking alcohol in a harmful way or when dependent on alcohol), and adult failure to thrive (decline in health and ability for older individuals).</p> <p>During a review of Resident 44's H&P dated [DATE], the H&P indicated Resident 44 has the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 44's MDS, dated [DATE], the MDS indicated Resident 44's cognitive skills were mildly impaired. The MDS indicated Resident 44 is dependent for shower transfers, required moderate assistance for bathing, chair/bed-to-chair transfer, lower body dressing, and required supervision for personal, toileting, and oral hygiene, dressing the upper body, and required set up for eating. The MDS indicated Resident 44 utilized a walker for mobility and does not have any impairments on both the upper and lower extremities. The MDS indicated Resident 44 had little interest or pleasure in doing things and feeling down, depressed, or hopeless for several days (two to six days).</p> <p>During a review of Resident 44's Order summary report as of [DATE], the report indicated, on [DATE], monitor for side effects of Lithium (used to treat mania part of bipolar disorder (manic-depressive illness); signs and symptoms of lithium toxicity severe nausea and vomiting, severe hand tremors, vision changes, unsteadiness when standing, loss of appetites, excessive thirstiness, need to urinate frequently, uncontrollable bowel movements, confusion, and blackouts every shift for lithium side effect monitoring.</p> <p>During a review of Resident 44's Medication Administration Record (MAR: document to keep track of medications given to residents) dated [DATE] to [DATE], the MAR indicated in the section for monitor for side effects of lithium, on [DATE] and [DATE] from 7:00a.m to 3:00p.m. and 3:00p.m. to 11:00p.m. shift indicated Resident 44 had signs and symptoms of lithium toxicity. Additionally, on [DATE] and [DATE] from 7:00a.m. to 3:00p.m. shift, the MAR was documented as X with a note indicating Resident 44 was sleeping. The options whether Resident 44 had any signs and symptoms were a Yes/No (Y/N).</p> <p>During a concurrent interview and record review of the MAR dated [DATE] to [DATE] on [DATE] at 6:12p.m. with DON, the DON stated if the resident has any signs and symptoms, it will indicate yes. The DON stated Resident 44 did have side effects on [DATE] and [DATE], but the signs and symptoms are not specific as to what type of symptoms Resident 44 had. The DON stated if side effects were observed, it would have been clarified with the doctor.</p> <p>d) During a review of Resident 42's Admission record, the Face Sheet indicated Resident 42 was admitted to the facility on [DATE] and with diagnoses including benign prostatic hyperplasia (BPH: non-cancerous enlargement of the prostate gland (small gland located in male reproductive system) with lower urinary tract symptoms (frequent urination, urgency, incontinence (loss of bladder control), overactive bladder, and malignant neoplasm of prostate (type of cancer that originates in the prostate gland).</p> <p>During a review of Resident 42's H&P dated [DATE], the H&P indicated Resident 42 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42's cognitive skills were intact. The MDS indicated Resident 42 required supervision for toilet transfer and bathing, required set up for toilet hygiene, chair/bed to chair transfer, dressing the lower body, and was independent on all other aspects of activities of daily living. The MDS indicated Resident 42 utilized a wheelchair and a walker and did not have any impairments on both the upper and lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the MAR dated [DATE] to [DATE], the MAR indicated Flomax oral capsule 0.4 mg (Tamsulosin Hydrochloride (HCL: treat symptoms of an enlarged prostate) one capsule by mouth one time a day for BPH was ordered on [DATE], discontinued on [DATE], and restarted on [DATE]. Terazosin HCL (treat symptoms of an enlarged prostate) oral capsule 5 mg one capsule by mouth at bedtime related to benign prostatic hyperplasia with lower urinary tract symptom ordered [DATE] was discontinued on [DATE].</p> <p>During a review of the consultant Pharmacist's Medication Regimen Review (MRR: evaluation of resident's medications to identify potential problems and prevent adverse reactions) dated [DATE] and [DATE], the MRR indicated second (2nd) request/please follow up if medical doctor (MD) has responded to this: Resident 42 has therapeutic duplication - Terazosin 5 mg once a day and Tamsulosin 0.4 mg once a day for BPH. Informed charge nurse (CN) on [DATE] to contact MD to discontinue (d/c) one order.</p> <p>During a concurrent interview and record review of the MRR on [DATE] at 3:37p.m. with RN 1, the RN 1 stated she was the one that had discontinued Terazosin in November. The RN 1 stated one of the medications for BPH should have been discontinued back in October and the nurse should have contacted the doctor, but it was not done.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug management, revised [DATE], the P&P indicated it was the policy of this facility to ensure that residents who have not used psychotropic drugs are given to help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, promote resident safety and security, and to enhance the resident's ability to interact positively with his/her environment. The facility will ensure clinically significant adverse consequences are minimized. The facility will continuously manage efforts to reduce dosage or discontinue psychotropics as appropriate and as indicated by regulations. The physician will review drug regimen monthly determine if resident need to remain on the same dose or if adjustment should be made. The P&P indicated if the desired therapeutic effect is not achieved on the medication ordered, the Attending Physician may request a psychiatrist and/or psychologist consultation. Unless clinically contraindicated, the Attending Physician will attempt a Gradual Dose Reduction (GDR). Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence. If a dose reduction was not successful, a note will be written on the physician progress notes justifying continued use of the medication.</p> <p>During a review of the facility's P&P titled, Resident's rights, undated, the P&P indicated the residents have the right to choose a treatment and participate in decision making and care planning. The P&P indicated residents have the right to be fully informed and participate in their treatment.</p> <p>46415</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview and record review, the facility failed to administer medications appropriately for one (Residents 39) of three residents observed during the medication pass. During medication pass, there were two medication errors out of twenty-six opportunities.</p> <p>These medication administration errors resulted to a medication error rate of 7.69 percent.</p> <p>Findings:</p> <p>During a review of Resident 39's Admission Record, the record indicated Resident 39 was admitted to the facility on [DATE] with a diagnosis including malignant neoplasm (cancer - abnormal mass of cells that grows uncontrollably and can spread to other parts of the body) of breasts.</p> <p>During a review of Resident 39's Minimum Data Set (MDS), a resident assessment tool, dated 12/29/2024, the MDS indicated Resident 39's cognition (ability to think) was intact. The MDS indicated Resident 39 needed substantial assistance (helper does more than half the effort)</p> <p>when eating, performing oral hygiene, toileting hygiene, personal hygiene, and dependent (helper does all the effort) on staff for showering assistance.</p> <p>During a review of Resident 39's Order Listing Report, 6/1/2024 to 7/31/2024, the summary indicated, Revised 1/3/2025, Anastrozole (medication for malignant neoplasm) one milligram (mg - unit of measure) give one tablet by mouth one time a day use gloves to handle.</p> <p>During a review of Resident 39's Order Listing Report, 6/1/2024 to 10/31/2024, the summary indicated, Revised 1/2/2025, Lidocaine external patch 5 percent (medication used to relieve pain), apply to left upper chest one time a day for pain management, On at 9:00 a.m. and OFF at 9:00 p.m. and remove per schedule.</p> <p>During an observation and interview on 1/14/2025 at 9:01 a.m. at Resident 39's bedside, with Licensed Vocational Nurse (LVN) 3, Resident 39's Anastrozole medication label was reviewed, and the label indicated use gloves to handle. LVN 3 was observed putting Resident 39's Anastrozole in a medication cup with without using gloves. LVN 3 administered Resident 39's medication without gloves.</p> <p>During a continued observation and interview on 1/14/2025 at 9:04 a.m. at Resident 39's bedside, with Resident 39, Resident 39 was noted to have a lidocaine patch still on the left chest and Resident 39 stated that the nurses did not take out the lidocaine patch last night.</p> <p>During a follow up interview on 1/14/2025 at 9:08 a.m. with LVN 3, LVN 3 stated the lidocaine patch should have been removed last night and she should follow directions when administering medications.</p> <p>During an interview on 1/17/2025 at 6:01 p.m., with the Director of Nursing (DON) the DON stated medications should be administered as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Medication Administration - General Guidelines, effective 10/2017, the P&P indicated, medications are administered as prescribed in accordance with good nursing principles and practices.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on observation, interview and record review, the facility:</p> <p>a. Failed to ensure medications for one of three residents (Resident 41) were stored in a secure location.</p> <p>b. Failed to ensure the medication refrigerator temperature was within normal range (30 to 4g degrees Fahrenheit).</p> <p>These deficient practices had the potential to result in unauthorized use of medications and the loss of viability (ability to work) of medication for improper storage temperature.</p> <p>Findings:</p> <p>During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was originally admitted to the facility on [DATE] with diagnoses including allergic rhinitis (inflammation [redness and swelling] of the inside of the nose) and asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways which makes it harder to breathe).</p> <p>During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool), dated 8/13/2024, the MDS indicated Resident 41's cognition was intact. The MDS indicated Resident 41 needed set up assistance with all Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 41's Physician Order Report: active orders as of 1/15/2025, the report indicated the following:</p> <p>1) Ordered 8/21/2024, Artificial Tears ophthalmic solution (eye drops to treat dry eyes) instill one drop in both eyes four times a day.</p> <p>2) Ordered 8/21/2024, Fluticasone Salmeterol Inhalation aerosol powder breath activated (medication to treat asthma) 250-50 micrograms/ actuation (unit of measure)</p> <p>3) Ordered 8/21/2024, Ipratropium Bromide Nasal Solution 0.03 percent (medication to treat allergic rhinitis), 2 spray each nostril three times a day.</p> <p>4) Sodium chloride nasal solution 0.65% (salt mixed with water used to rinse sinuses) 1 spray both nostrils two times a day.</p> <p>During an observation and interview on 1/13/2025 with the Director of Saff development (DSD), the medication refrigerator was noted to have a temperature reading of 48 degrees Fahrenheit. The DSD read the temperature log and stated the refrigerator temperature should be 30 degrees to 46 degrees.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the administrator (ADM) on 1/14/2025 at 8 a.m., the Administrator said the medication refrigerator need to be within range, so the refrigerator was replaced immediately.</p> <p>During an observation and interview on 1/14/2025 at 8:12 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 41 was observed self-administering artificial tears, Fluticasone Salmeterol Inhalation aerosol powder, Ipratropium Bromide Nasal Solution, Sodium chloride nasal solution 0.65% in front of LVN 2 and storing medication at his bedside. LVN 2 confirmed and stated Resident 41's medications he self-administered were in his safekeeping, in his luggage.</p> <p>During an interview on 1/15/2025 at 1:19 p.m., with Registered Nurse Supervisor (RN) 1, RN 1 stated Resident 41's nasal sprays, eye drop, and inhaler medication should be stored in the medication cart for safekeeping.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415</p> <p>Based on interview and record review, the facility failed to inform the physician about an abnormal laboratory (bodily specimen test process and resulting) result in a timely manner for one of one sampled resident (Resident 44).</p> <p>This deficient practice placed Resident 44 at risk for delayed treatment of abnormal laboratory results.</p> <p>During a review of Resident 44's Admission Record, the Admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) with current episode manic without psychotic features, alcohol abuse (drinking alcohol in a harmful way or when dependent on alcohol), and adult failure to thrive (decline in health and ability for older individuals).</p> <p>During a review of Resident 44's History and Physical (H&P) dated 11/10/2024, the H&P indicated Resident 44 had the capacity to understand and make decisions.</p> <p>During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 44's cognitive (ability to make decisions of daily living) skills were mildly impaired. The MDS indicated Resident 44 is dependent for shower transfers, required moderate assistance (assists with less than half the effort) for bathing, chair/bed-to-chair transfer, lower body dressing, and required supervision for personal, toileting, and oral hygiene, dressing the upper body (above waist), and required set up for eating. The MDS indicated Resident 44 utilized a walker for mobility and does not have any impairments on both the upper (shoulders/arms) and lower extremities (hip, legs). The MDS indicated Resident 44 had little interest or pleasure in doing things and was feeling down, depressed, or hopeless for several days (two to six days).</p> <p>During a review of Resident 44's Order summary report as of 1/15/2025, the order summary report indicated an active order of Lithium Carbonate (treat manic-depressive disorder (bipolar disorder) oral capsule 300milligram (mg: a unit of mass) by mouth two times a day related to bipolar disorder, current episode manic without psychotic features unspecified (manifested by (m/b) recurrent behavior fluctuations from depressed behaviors to manic behavior and vice versa every shift) on 11/21/2024.</p> <p>During a review of the order listing report dated 11/15/2024 to 1/31/2025, the order listing report indicated lithium level laboratory (lab) blood test one time only for one day ordered and completed on 12/17/2024.</p> <p>During a review of the lab results report dated 12/18/2024, the lab result indicated the lithium was collected on 12/18/2024 at 5:52 a.m., and was received on 12/18/2024 at 11:01 a.m. The lithium result indicated it was high at 1.10 millimoles per liter (mmol/L: unit of measurement used in some medical tests) (reference range of (0.50 - 1.00) .</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the progress note dated 12/23/2024 at 11:08 a.m., the progress note indicated lab results were relayed to the doctor by phone.</p> <p>During an interview on 1/15/2025 at 3:14 p.m., with Registered Nurse (RN) 1, RN 1 stated if lab results are received, the doctor should be notified right away especially since lithium can cause lithium toxicity and can be detrimental to the residents health.</p> <p>During a concurrent interview and record review on 1/17/2025 at 12:39p.m. with Licensed Vocational Nurse (LVN 4), Resident 44's lab report dated 12/18/2024 were reviewed. LVN 4 stated if there is an abnormal lab result, you inform the doctor right away. LVN 4 stated based on the lab report dated 12/18/2024 and the progress note dated 12/23/2024 notifying the doctor is not acceptable as Resident 44's physician was notified five days later and may result in a delay in care.</p> <p>During a review of the facility's P&P titled, Job Title: Licensed Vocational Nurse (LVN), undated, the P&P indicated reporting/triaging abnormal test results reports all abnormal test results to physician in a timely manner; triages activities based on borderline and/or abnormal and/or unusual findings.</p> <p>During a review of the facility's P&P titled, Laboratory, Diagnostic and Radiology Services, dated February 9, 2024, the P&P indicated the ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner's order.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777</p> <p>Based on observation, interview, and record review, the facility failed to ensure Resident 34 had a peanut butter sandwich that was requested for a snack.</p> <p>This deficient practice had the potential to affect the resident's rights , wellbeing and can lead to insufficient food intake.</p> <p>Findings:</p> <p>During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including malignant neoplasm of unspecified part of unspecified bronchus (cancer of the large airway that leads from the windpipe to the lungs), Anemia (lack of blood) and acute on chronic systolic congestive heart failure (a weekend heart condition that causes fluid buildup in the feet , arms, lungs and other organs).</p> <p>During a review of Resident 34's History and Physical (H&P) dated 10/3/2024, the H&P indicated Resident 34 has fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 34's Minimum Data Set [(MDS), resident assessment], Resident 34 is dependent (resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene, upper and lower body dressing and sit to lying and chair/bed to chair transfer and partial/moderate assistance (helper lifts, holds trunk or limbs and provides more than half the effort with eating.</p> <p>During a record review of Resident 34's Order Summary Report (OSR) dated 11/27/2024, the OSR indicated may have peanut butter/ jelly sandwich (no crust), bananas, and saltine/graham crackers during 2 p.m. snack time.</p> <p>During a review of Resident 34's care plan initial date 10/4/2024 indicated Resident 34 is at risk for aspiration and weight loss resident requested peanut butter and jelly sandwiches (no crust) Bananas and saltine / graham crackers during 2 p.m. snack time. The interventions were speech therapist evaluation as needed weekly weights and diet as ordered.</p> <p>During a record review of Resident 34's Speech Therapy Treatment Encounter Note ([NAME]), the [NAME] indicated patient utilized techniques with moderate verbal instructions on seven out of 10 attempts. Order written for patient to receive peanut butter and jelly sandwich (no crust), banana, and crackers during 2 p.m. snack pass each day.</p> <p>During an initial interview on 1/13/2024 at 11:15 a.m. with Resident 34, Resident 34 stated every time we have snack time I request for a peanut butter and jelly sandwich I also ask for soda crackers or ritz crackers they do not give them to me.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 1/14/2025 at 2:30 p.m. observed Resident 34 in wheelchair with bedside table in front and resident eating vanilla pudding Resident stated he did not get a peanut butter and jelly sandwich and the facility gave me yogurt.</p> <p>During an interview on 1/16/2025 with Resident 34's roommate, Resident 97 stated I heard Resident 34 request for a peanut butter and jelly sandwich, and I am not going to lie they gave him a yogurt cup.</p> <p>During an interview on 1/16/2024 at 2:45 p.m. with Certified Nurse Assistant 7 (CNA7), CNA 7 stated snacks are out at 10:00 a.m. and 2:00 p.m. CNA 7 stated she gave resident 34 a yogurt cup for 10:00 a.m. and 2:00 p.m. CNA 7 stated the kitchen put snack cart out at the nurse's station for each resident the charge nurse or the dietary aide let me know what snack is for the resident.</p> <p>During an interview on 1/16/2024 at 2:55 p.m. with the Dietary Aide 2 (DA 2) , DA 2 stated she prepare snacks according to the nourishment list . DA 2 stated I always give resident 34 yogurt at 10:00 a.m., 2:00 p. m. and 7:30 p.m. because it is on his list of nourishment. DA 2 stated resident did not get a peanut butter and jelly sandwich it is not on his nourishment. DA 2 stated it is important to give Resident 34 peanut butter and jelly sandwich that was ordered by the doctor ordered he asks for because it is part of his diet, and we want to make sure Resident 34 is full and satisfied.</p> <p>During an interview on 1/16/2024 at 3:04 p.m. with Dietary Supervisor (DS), DS stated my job is to make recommendations pertaining to a resident's diet he stated I make rounds to the resident's room to find out their food preference. DS looked at the doctor's order for a peanut butter and jelly sandwich at 2 p.m. and stated It is my fault I missed this order. DS stated we need to adhere residents request and diet recommendations as the doctors ordered.</p> <p>During an interview on 1/16/2024 at 3:15 p.m. with the Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated her job is to check the nourishment to make sure they are getting the right snack. LVN 4 stated she check the diet against the Medical Records and missed that order for peanut butter and jelly sandwich for 2:00 p.m. The LVN 4 stated the importance of adhering to the doctor's order and the residents request is so the residents can be happy , to make them comfortable and to make sure they are eating.</p> <p>During an interview with the Director of Nursing (DON) , the DON stated the Speech Therapist (a health professional who helps people improve their swallowing skills) give the diet orders to dietary and dietary prepares and put the sacks out for the CNAs to give to the residents. DON stated there was a break in communication Resident 34's diet was missed, and this can make the resident dissatisfied of the situation.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food Preference, dated 2023 the P&P indicated, Residents food preferences will be adhered to within reason. Food preference shall be obtained as soon as possible through the initial resident screen.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Nourishment Policy, dated 2023 the (P&P) indicated, nourishments or in between snacks shall be provided when required by the diet prescription. The food and nutrition services Department will prepare the nourishments / snacks and deliver them to the nursing stations at the specified times. Note that suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non- traditional times or outside of scheduled meals service times, consistent with the resident's plan of care and diet orders. It is the Nursing department's responsibility to see that each resident received the nourishments as ordered.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>38740</p> <p>Based on observation, interview and record review, the facility failed to ensure staff followed food production recipes and fortified diet (diet to increase caloric intake) guidelines during lunch preparation and tray line observation on 1/13/2025 when:</p> <ol style="list-style-type: none"> 1.cook used small scoop size to serve pureed fish for residents on pureed diet. 10 residents on pureed diet received 3/8 cup (3 ounces (oz.)) of pureed fish instead of 1/2 cup (4ounces (oz.)) per menu. Three residents on the renal diet (a diet aimed at keeping levels of fluids, electrolytes, and minerals balanced in the body in individuals with kidney disease or who are on dialysis) received peas for lunch instead of green beans per menu. 2.Fortified diets (diet enhanced to increase caloric content) were not prepared and were not served to residents who were on fortified diet. <p>These deficient practices had the potential to result in meal dissatisfaction, decreased caloric intake and weight loss for 10 residents on pureed diet who received less protein and seven residents who required a fortified diet.</p> <p>Findings:</p> <p>According to the facility lunch menu for pureed diet and renal diet on 1/3/2025, the following items will be served.</p> <p>Pureed diet: Fish fillet with tarragon sauce pureed #8 scoop yielding 1/2 cup; Cajun country rice pureed, creamed spinach pureed, sweet corn salad pureed, fruit Bavarian cream and milk.</p> <p>Renal Diet: Fish fillet with tarragon sauce, Cajun country rice with no ham #12 scoop yielding 1/3 cup, green beans with margarin 1/2 cup, sweet corn salad 1/2, canned peaches, and beverage.</p> <p>During an observation of the tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on 1/13/2025, at 12:09 PM, residents who were on pureed diet the cook served pureed fish fillet using the #10 scoop yielding 3 oz or 3/8 cup instead of #8 scoop or 1/2 cup per menu.</p> <p>During the same observation for lunch on 1/13/2025, at 12:09PM residents who were on renal diet received peas 1/2 cup instead of the green beans per the menu.</p> <p>During an interview with cook (Cook1) and Dietary Supervisor on 1/13/2025 at 12:35PM Cook1 reviewed the daily spreadsheet (portion and serving guide) and stated she made a mistake on the scoop size and served pureed fish using a smaller scoop. Cook1 stated the spreadsheet and portion guide indicated serve pureed fish using #8 scoop (1/2 cup) Cook1 stated residents on pureed diet received less protein than residents on regular diet. Cook1 stated receiving less food can result in unwanted weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the same interview with cook (Cook1) and Dietary Supervisor (DS) on 1/13/2025 at 12:35PM, cook1 stated she did not look at the menu for the renal diet. Cook1 stated she served peas instead of green beans for residents on the renal diet. Cook1 stated green beans was on the menu and it was not changed, Cook1 made a mistake and forgot to look at the menu. Cook1 stated when residents receive the wrong menu they can get upset and not eat the food. DS stated, cooks should always follow the menu for the portion size and the right food to serve.</p> <p>During a review of facility policy titled Menu Planning Policy #3.1 (dated 2023) indicated, all daily menu changes, with the reason for the change are to be noted on the back of the kitchen spreadsheet, only facility RD and DS can make these changed. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders and recommended dietary allowances.</p> <p>2. During the tray line observation on 1/13/2025 at 12:09 PM, residents who were on fortified diet, Dietary Aide (DA1) did not communicate the fortified diet orders written on the meal tickets during tray line for lunch service. A review of resident's tray or meal tickets on the cart indicated the orders for fortified diets. However, DA1 did not read out loud the fortified diet and Cook1 who was serving the food did not add any additional food items per fortified menu.</p> <p>During a concurrent observation and interview with Cook1 on 1/13/2025 at 12:30PM, Cook1 stated when there is a fortified diet, melted margarine is added to the vegetables or starch during lunch. Cook1 stated during lunch service DA1 will read out the fortified diet that are written on the meal tickets and cook1 will add melted margarine to the meal. Cook1 stated DA1 did not announce or read out the fortified diets during the lunch service and cook1 did not add any margarine to food. Cook1 stated fortified diets are for residents who have weight loss and fortify diet adds more calories. Cook1 stated fortified diets are important to prevent weight loss.</p> <p>During a concurrent observation and interview with DA1 and infection prevention nurse (IPN) on 1/13/2025 at 12:45PM, regarding diet fortification process, IPN was checking lunch tray for accuracy of the diet and meals served. IPN stated she does not know how the kitchen fortified the food for lunch and IPN can't tell by looking at the food. IPN spoke with DA1 who was next to the meal carts and began translating for DA1. DA1 stated fortified diets are for residents who need more calories because they are losing weight. DA1 stated some residents get fortified milk, which is nonfat powder milk added to regular milk. DA1 reviewed one of the meal tickets and stated fortified diet is also written on the meal tickets. DA1 stated she should read out the diet orders to the cook during lunch service. DA1 stated she did not read out the fortified diet orders as written on the meal ticket. DA1 stated residents did not receive fortified food she stated if residents don't receive fortified food they will lose weight.</p> <p>During an interview with Registered Dietitian (RD) on 1/14/2025 at 10:00AM, RD stated Fortified diets add extra calories and protein to food. Fortified is for residents who are experiencing weight loss and additional calories can help. RD stated some residents get fortified milk with lunch and melted margarine is added to the vegetables or starch. RD stated when residents don't get the fortified diets they can lose weight.</p> <p>(continued on next page)</p>		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility policy titled Fortification of Food Policy # 4.19 (dated 2023) indicated, The goal to increase the calorie and or protein density of the foods commonly consumed by the resident to promote improvement in their nutrition status . Calories and protein will be added to selected food .Food and Nutrition services staff will be familiar with the fortification process for each item chosen to be used at the facility . 1/2 oz. melted margarine is added to 1 food item for breakfast, 2 items at lunch and 1 at dinner . adds 100 calorie per 1/2 oz.		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>38740</p> <p>Based on observation, interview and record review, the facility failed to ensure:</p> <p>1. One resident (Resident 2) who was on mechanical soft texture diet (soft food) received quesadilla (a Mexican dish consisting of a tortilla that is filled with cheese and then cooked on a griddle or stove) texture in form that meet their needs when the quesadilla was dry with hard and golden brown crispy edges, was not chopped and resident was not able to eat and stated it was overcooked.</p> <p>This deficient practice had the potential to result in decrease intake related to inconsistent texture, meal dissatisfaction, and increase choking and aspiration risk.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, the admission record indicated the facility initially admitted Resident 2 on 5/2/2024 with diagnosis including, but not limited to chronic obstructive pulmonary disease (COPD, a common lung disease causing restricted airflow and breathing problems), Dysphagia, Oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat.)</p> <p>During a review of Resident 2's physician diet order, dated 5/2/2024, Resident 2's physician diet order indicated Resident 2 diet was Mechanical soft Fortified diet (a diet with foods that were modified in texture to soft, chopped or ground consistency.) give soup for Lunch and Dinner per resident request.</p> <p>During an observation of meal preparation in the kitchen on 1/13/2025 at 12:09PM Resident 2 who was on mechanical soft diet texture (diet for resident who experience chewing or swallowing limitation. Diet is modified to a soft, chopped or ground consistency.) received quesadilla with tortilla that was dry with golden-brown crispy edges. The quesadilla consisted of two large tortillas (round flat bread) and melted cheese in between. Cheese was mainly in the middle of the tortillas leaving the edges dry. The quesadilla then was cut into quarters and served.</p> <p>During an interview with cook2 on 1/13/2025 at 12:15PM Cook2 stated cook2 prepared the quesadilla using 2 large flour tortillas and shredded cheese in the middle and then grilled the tortillas on pan with melted margarine. Cook2 did not use a recipe for the quesadilla.</p> <p>During a meal observation on 1/13/2025 at 1:00PM in Resident 2's room, the lunch tray with quesadilla was sitting on Resident 2 bed side table. The cheese quesadilla was cut into 4 quarters, only the soft middle part was eaten, one bite was taken from each of the quarters. the rest of the quesadilla with the dry and brown edges of the tortilla was left on the plate.</p> <p>During the same meal observation and interview with Resident 2 on 1/13/2025 at 1:00PM, Resident 2 had missing teeth. Resident 2 stated, she received quesadilla today for lunch, but she could not eat the quesadilla because it was overcooked and well done. Resident 2 stated the quesadilla was dry and I don't like it. Resident 2 started getting upset and requested not to get quesadilla anymore. Resident 2 stated she dislikes pork and meat, but she didn't say bring me quesadilla.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the same observation and interview with Dietary Supervisor (DS) on 1/13/2025 at 1:00PM, DS stated the quesadillas should be softer, the resident is on mechanical soft diet. DS stated if the quesadillas were cooked differently, and softer Resident 2 would not have any problems.</p> <p>During a concurrent observation and interview with CNA 5 and CNA 6 on 1/13/2025 at 1:10PM, CNA 5 stated resident receives the menu every day and some days will request an alternative to the lunch menu and usually it is the quesadilla. CNA 5 stated Resident 2 requested quesadilla today, but she didn't eat it because it was dry.</p> <p>During an interview with Registered Dietitian (RD) on 1/14/2025 at 10:00AM RD stated Resident 2 orders quesadilla very often. RD stated resident 2 also prefers creamy soup with lunch and dinner, RD stated Resident 2 is on mechanical soft and fortified diet and is aware that Resident 2 has missing teeth. RD stated mechanical soft diet means the quesadilla should be made soft with no hard or dry edges. The quesadilla should be either chopped (cut into small pieces or ground if indicated) RD stated Resident 2 tolerates chopped diet so the quesadilla needs to be cut into further strips for easy consumption., RD also stated Resident 2 is on fortified diet which means resident meals are added with extra melted margarine or cheese to enhance the caloric content of food. RD stated quesadilla was not made fortified because it is in an alternative to the lunch and alternatives are not fortified.</p> <p>A review of Resident 2 diet order listed on the facility order listing report dated 1/13/2025 indicated Mechanical soft Fortified diet. Give soup for Lunch and dinner per resident's request.</p> <p>A review of facility policy and procedure for the Regular mechanical soft diet (dated 2023) indicated Foods to avoid are breads with hard crusts, foods allowed are soft breads and soft tortillas.</p> <p>A review of facility policy and procedures titled Menu Planning (dated 2023) indicated, Standardized recipes adjusted to appropriate yield shall be maintained and used in the food preparation.</p> <p>A review of facility policy and procedures titled Fortification of Food (dated 2023) indicated, The goal is to increase the calorie and or protein density of the foods commonly consumed by the resident to promote improvement in their nutrition status .1/2 oz melted margarine may be added to food item . Adds 100 calories per 1/2 oz.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38740</p> <p>Based on observation, interview and record review the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when:</p> <ol style="list-style-type: none"> 1. One open bag of frozen pepperoni with and one large plastic bag of diced chicken were stored in the freezer with no open date or label. One bag of frozen chicken thighs stored uncovered in the reach in freezer. 2. One Dietary Aide (DA1) working in the dish machine area did not wash hands and change gloves when removing the clean and sanitized dishes from the dish machine. 3. Dishware were not sanitized with adequate amount of sanitizer per manufactures guidelines. Sanitizers and disinfectants are used on food contact surfaces to prevent food borne illness. <p>These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 45 out of 48 residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation in the kitchen on 1/13/2025 at 9:12AM there was one open bag of pepperoni with no open date stored in the reach in freezer, there was one large blue plastic bag with food item stored in the same reach in freezer with no label or date. The contents of the blue bag could not be seen. <p>During the same observation and interview, DS stated pepperoni was opened and used and there should be an open date on it to discard per storage guidelines. DS stated the blue plastic bag contains diced chicken and it should be labeled once it is out of the original container. DS stated labeling bags is important for proper identification of the food.</p> <p>During a concurrent observation in the reach in freezer and interview with DS on 1/13/2025 at 9:15AM, there was one bag of frozen chicken thighs stored in the reach in freezer. The bag was open, and the frozen chicken was exposed to the freezer environment. The frozen chicken thighs had ice and frost bite on the surface, it looked dry and discolored. DS stated the bag should be covered to prevent cross contamination. DS discarded the frozen chicken.</p> <p>A review of facility policy titled Procedure for Freezer Storage (dated 2023) indicated, All frozen food should be labeled and dated.</p> <p>A review of facility policy titled Procedure for Refrigerated Storage (dated 2023) indicated, Individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated. Freezer burn may occur before that and reduce the maximum shelf life. Food that has been freezer burned must be discarded.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#3-501.17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded.</p> <p>2.During an observation in the dishwashing area on 1/13/2025 at 9:20AM, Dietary Aide (DA1) was rinsing soiled dishes and loading the dirty dishes in the dish machine. DA1 had gloves on her hands and proceeded to remove the clean and sanitized dishes form the dish machine without washing hands and replacing gloves.</p> <p>During a concurrent interview DA1 stated she forgot to remove gloves and wash hands before touching the clean dishes. DA1 stated she usually will go to the sink and wash hands and replace gloves. DA1 stated not changing gloves and washing hands can contaminate clean dishes and can make residents sick.</p> <p>During an interview with Dietary Supervisor (DS) on 1/13/2025 at 9:20AM, DS stated DA1 contaminated the clean dishes when touching with the same dirty gloves. DS stated staff should wash hands and replace gloves when moving from a task that contaminated hands to a clean task. Dirty dishes can cause food borne illness in residents.</p> <p>A review of facility policy titled, handwashing Procedure. (dated 2023) indicated when hands need to be washed: After handling soiled dishes and utensils.</p> <p>A review of facility policy titled, Glove use Policy (dated 2023) indicated, When gloves need to be changed . before beginning a different task.</p> <p>A review of the 2022 U.S. Food and Drug Administration Food Code, Code 2-301.14 When to Wash. Indicated, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately E) After handling soiled EQUIPMENT or UTENSILS.</p> <p>3.During an observation of the dish machine area on 1/13/2025, at 9:48AM, DA1 was loading dishes in the dishwashing machine. DA1 stated the dishwashing machine uses chlorine sanitizer to sanitize the dishes. DA1 was asked to demonstrate dish machine operation and sanitizer effectiveness. DA1 immersed the test strip in the rinse water and compared to color chart that showed sanitizer was not in range. The recommended concentration level for chlorine sanitizer is between 50-100 parts per million (PPM). The test strip compared to color chart indicated less than 50PPM.</p> <p>During the same observation and interview DS stated the machine was working this morning and the sanitizer test was effective.</p> <p>A concurrent review of the dishwashing sanitizer log record dated 1/13/2025, indicated the sanitizer was at 50 PPM effective for breakfast shift.</p> <p>During a concurrent observation and interview with DS on 1/13/2025, at 10:00AM DS stated the chlorine sanitizer is running low and changed the sanitizer bucket that was attached to the dishwashing machine. DS started the dishwasher over again and retested the sanitizer solution five times.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of the dishwashing machine on 1/13/2025, at 10:20AM the sanitizer test strip indicated 50PPM and sanitizer was effective.</p> <p>During an interview with DS on 1/13/2025, at 10:30AM, DS stated the dishes were not sanitized and will be rewashed and sanitized effectively. DS stated there has not been any issues with the machine prior to today and the dishwasher technician will come in to make sure dishwasher is working properly.</p> <p>A review of facility policy titled Dishwashing (dated 2023) indicated, All dishes will be properly sanitized through the dishwasher. The dish machine is to be serviced on a regular basis by a technician to ensure accurate measurements of sanitizing agents. The chlorine should read 50-100PPM on dish surface in final rinse the proper chlorine level is crucial in sanitizing the dishes.</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>44055</p> <p>Based on interview and record review, the facility failed to provide documented evidence of 10 hours of continued education in the field of Infection Prevention and Control (IPC) for the one of one facility staff (Infection Prevention Nurse -IPN).</p> <p>This failure had the potential to result in negative health outcomes for the staff and residents of the facility.</p> <p>Findings:</p> <p>During an interview on 1/16/2025 at 9:07 a.m., with the IPN, the IPN stated she did not have annual 10 hours of continuing education in the field of Infection Prevention and Control after the initial IP training was completed in 2023.</p> <p>During a record review of the California Department of Public Health All Facilities Letter (AFL) 20-84, titled, Infection Prevention Recommendations and Incorporation into the Quality and Accountability Supplemental Payment (QASP) Program, 11/4/2020, the AFL indicated it was important that each facilities Infection Preventionist have training in fundamental Infection Prevention and Control principles to effectively perform the IP duties. Ongoing education was necessary to remain aware of new information, trends, best practices, and to refresh existing knowledge. The AFL indicated The IP should complete 10 hours of continuing education in the field of IPC on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association.</p>		

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NAME OF PROVIDER OR SUPPLIER Villa Serena Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 9th Street Long Beach, CA 90813	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44055</p> <p>Based on interview and record review the facility failed to ensure the facility's Water Management Plan (plan that identifies hazardous conditions and steps to take to minimize the growth and spread of bacteria[germs]) was implemented when the water management assessment was not completed.</p> <p>This deficient practice had the potential to expose residents and staff to Legionella (bacteria that can cause serious lung infections) and waterborne infections.</p> <p>Findings:</p> <p>During an interview and record review on 1/16/2025 at 9:19 a.m., there was no documented facility water management plan, and the Infection Prevention Nurse (IPN) confirmed the water management assessment was not completed. The IPN stated we need to complete the assessment to ensure microbial growth (germs) was not spreading.</p> <p>During an interview with the Administrator on 1/16/2025 at 1:00 p.m. the administrator stated the facility will complete the water management assessment because it was required.</p> <p>During a review of the facility policy and procedure (P&P) titled Legionella, implemented 2/9/2024, the P&P indicated the facility will follow guidance issued by the Centers for Disease Control (CDC) and complete the risk assessment in developing a water management plan to reduce Legionella. As indicated the facility will contract with experts to assist in the development of the water management plan. The facility will consider internal and external factors that may contribute to legionella growth.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055</p> <p>Based on interview, and record review, the facility failed to implement its protocol for antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics by clinicians) by not monitoring the side effects and addressing antibiotic (a substance used to kill bacteria and to treat infection) use for one of two sampled residents (Resident 16).</p> <p>This failure had the potential for the Resident 16 to receive inappropriate antibiotics and develop adverse reactions for long term antibiotic use.</p> <p>Findings:</p> <p>During a review of Resident 16's Admission record, the Admission record indicated Resident 16 was admitted to the facility on [DATE] with diagnosis including hepatic encephalopathy (a brain disorder that occurs when the liver fails and toxins build up in the blood).</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 12/11/2024, the MDS indicated Resident 16's cognition was intact. The MDS indicated Resident 16 needed supervision (helper provides verbal cues) when eating, performing oral hygiene, and moderate assistance (helper does less than half the effort) with showering, personal hygiene, and toileting hygiene.</p> <p>During a review of Resident 16's Physician Order, the order indicated 11/12/2024, Neomycin Sulfate Oral Tablet (antibiotic) 500 milligrams (mg - unit of measure), one tablet by mouth two times a day for hepatic encephalopathy.</p> <p>During an interview and record review on 1/16/2025 at 12:07 p.m., with the IPN, Resident 16's medical records and the IPN antibiotic stewardship binder was reviewed. Resident 16's order, 11/12/2024, indicated Neomycin Sulfate Oral Tablet 500 mg, one tablet by mouth two times a day for hepatic encephalopathy. The facility's antibiotic stewardship binder for November 2024 to January 2025 did not have Resident 16's neomycin. The IPN stated she did not review Resident 16's Neomycin use because she did it when originally readmitted on [DATE]. The IPN stated there was no documented evidence of the clinical indication for long term use of Neomycin. The IPN stated there was no documented evidence of monitoring of adverse reactions for Resident 16's long term use of Neomycin.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, 2/9/2024, the P&P indicated the Antibiotic Stewardship Program is designed to promote appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>44055</p> <p>Based on interview and record review, the facility failed to provide documented evidence of all employees screening, education, offering, and current Corona virus disease, COVID-19 (contagious infectious disease), vaccination (medications used to prevent diseases usually given by injection or by mouth) status.</p> <p>This failure had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to COVID-19.</p> <p>Findings:</p> <p>During an interview and record review on 1/16/2025 at 12:07 p.m., with the Infection Prevention Nurse (IPN), the facility's employee records of COVID-19 status 2024 to 2025 was reviewed, and the physicians and consultants COVID-19 immunization status were unknown. The IPN stated she did not know she had to get the physicians and consultants Covid-19 immunization status.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Covid-Vaccination, implemented 2/9/2024, the P&P indicated the policy was to prevent and minimize transmission of Covid-19. The P&P indicated the facility will educate and offer Covid-19 vaccinations to facility staff and consultants. The P&P indicated facility staff include all paid and unpaid individuals who work in indoor settings where care is provided to residents or have resident access for any purpose.</p>

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<p>F 0911</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777</p> <p>Based on observation , interview and record review, the facility failed to ensure two of 19 residents' bedroom , rooms(2 and 19) accommodate no more than 4 residents in each room.</p> <p>This deficient practice had the potential to result in inadequate space to provide nursing care.</p> <p>Findings:</p> <p>During an observation on 1/14/2025 at 3:14 p.m., observed room two occupied with six residents and room three was occupied with six residents . The residents were able to move in and out of their rooms and there was space for wheelchairs, beds, and bedside tables.</p> <p>During a record review of the waiver signed by the administrator dated submitted by the administrator indicated resident 2 and 3 did not meet the four resident per room requirement by federal regulation . The letter indicated room [ROOM NUMBER] and 3 had enough space to provide each resident care without affecting their health and safety or impeding any of the residents in the room to attain his or her wellbeing.</p>

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>45777</p> <p>Based on observation, intervention, and record review the facility failed to provide a minimum of 80 square feet (sq. ft.) for resident per resident in multiple rooms resident bedrooms (2, 3, 4, 5, 6, 7, 8, 9, 10, 11,12, 13, 14, 15, 16, 17, 18, and 19 for (17 of 19 residents room).</p> <p>This deficient practice had the potential to impact the ability to provide nursing care to the residents.</p> <p>Findings :</p> <p>During and observation on 1/14/2025 at 00:00 a.m., with the Maintenance (MN), observed multiple resident's rooms with two, three and six beds in a room. Observed residents go in and out of beds with adequate spacing, side tables, chairs, wheelchairs readily available without impeding any movement.</p> <p>During an interview on 1/14/2025 at 00:00 a.m., with the MN , the MN stated we have a room waiver now and will apply for one in 2025.</p> <p>During a review of the room size waiver dated 1/2024 submitted by the Administrator (ADM), for 17 residents' room was reviewed, the letter indicated there was ample room to accommodate residents and enough space for residents care and health and safety of the residents occupying these rooms.</p> <p>The letter indicated the following :</p> <table border="0"> <thead> <tr> <th>Room Number</th> <th>Beds</th> <th>Per Room</th> <th>Square Footage</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>2 6</td> <td>470</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>3 6</td> <td>426</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>4 2</td> <td>153</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>5 2</td> <td>155</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>6 2</td> <td>146</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>7 2</td> <td>145</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>8 2</td> <td>144</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>9 2</td> <td>144</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>11 2</td> <td>146</td> <td>sq. ft.</td> <td></td> <td></td> </tr> <tr> <td>12 3</td> <td>213</td> <td>sq. ft.</td> <td></td> <td></td> </tr> </tbody> </table> <p>(continued on next page)</p>			Room Number	Beds	Per Room	Square Footage	Total	2 6	470	sq. ft.			3 6	426	sq. ft.			4 2	153	sq. ft.			5 2	155	sq. ft.			6 2	146	sq. ft.			7 2	145	sq. ft.			8 2	144	sq. ft.			9 2	144	sq. ft.			11 2	146	sq. ft.			12 3	213	sq. ft.		
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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>13 3 187 sq. ft.</p> <p>14 2 129 sq. ft.</p> <p>15 2 133 sq. ft.</p> <p>16 3 210 sq. ft.</p> <p>17 3 214 sq. ft.</p> <p>18 3 216 sq. ft.</p> <p>19 3 217 sq. ft.</p> <p>The minimum sq. ft. for a two bedroom is 160 sq. ft.</p> <p>The minimum sq. ft for a three bedroom is 240 sq. ft.</p> <p>The minimum sq. ft. for a six bedroom, is 480 sq. ft.</p> <p>During the survey from 1/13/2025 to 1/18/2025, there were no observed adverse effects as to the adequacy of space nursing care comfort and privacy to the residents. There was ample space to accommodate wheelchairs, beds and other medical equipment including space for mobility and locomotion of residents.</p>