

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Edgewater Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 East Fourth Street Long Beach, CA 90814	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45537</p> <p>Based on observation, interview and record review, Licensed Vocational Nurse (LVN) 2 failed to ensure the pain medication for one (Resident 1) of five sampled residents was documented immediately in the narcotic sheet (document used to keep track of inventory of narcotic [medication that is highly addictive] medications) after the medication was administered, in accordance with the professional standards of practice.</p> <p>This failure has the potential for Resident 1 to be subjected to risk of undermedication and/ or overmedication due to untimely documentation of administered pain medication.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face sheet), the Face sheet indicated Resident 1 was admitted at the facility on 2/25/2022 with diagnosis including diabetes mellitus (a serious condition where the blood glucose, also known as blood sugar level of the body, is too high) with neuropathy (a condition when nerve damage leads to pain, numbness, and weakness).</p> <p>During a review of Resident 1's Order Summary, the Order Summary indicated Resident 1 has an order of Norco (is a combination of two medications, hydrocodone [a narcotic analgesic, a powerful pain reducing medication, which can be addictive] and Tylenol [a medication acts as a pain reliever and fever reducer) tablet 5/325 milligram (mg- a unit of measurement, which means a thousandth of a gram) 1 (one) tablet by mouth for pain management, to administer (give) 30 minutes prior to wound care.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) dated June 2024, the MAR indicated Resident 1 was given Norco 5/325 mg 1 (one tablet) by mouth on 6/12/2024 at 9 a.m.</p> <p>During an observation and interview on 6/12/2024 at 2:31 p.m., Licensed Vocational Nurse 2 (LVN) was standing by the medication cart in the facility's hallway and signing a page of the narcotic count sheets. LVN 2 stated he administered Norco to Resident 1 at 9 a.m. today and he was just signing off now the narcotic count sheet of Norco of Resident 1. LVN1 stated he could have signed off the narcotic count sheet immediately after administering Resident 1's pain medication to ensure the pain medication was documented timely and the pain medication was accounted for to prevent discrepancy and risks of overmedication and/ or undermedication of Resident 1.</p> <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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/12/2024 at 3 p.m., Licensed Vocational Nurse 3 (LVN 3) stated the right procedure of medication administration is to pour, pass and sign and the resident's narcotic count sheet must be signed and updated immediately after administering the medication to prevent a medication error.</p> <p>During an interview on 6/13/2024 at 2:31 p.m., the Director of Nursing Services stated the licensed nurses must sign the narcotic count sheet after giving the medication to determine the accurate timing of the dose given to the resident thus preventing unrelieved/ uncontrolled pain and duplication of medication administration.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Medication Administration- General Guidelines updated 11/2021, the P/P indicated the residents' medications are administered in accordance with good nursing principles and practices and the license nurse who administered the medication dose records/ documents the administration on the resident's medication administration record after the medication pass is completed.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Medication Storage in the Facility updated 8/2019, the P/P indicated the facility's current controlled substance accountability records are kept in the medication administration record or a designated book.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45537</p> <p>Based on interview and record review, the facility failed to account for the disposition of eight Morphine Sulfate (a drug used to treat moderate and severe pain and can be addictive) tablets in one of two emergency medication kits (receptacle that holds emergency medications) in the facility.</p> <p>This failure resulted in missing medications which could potentially be accidentally ingested by a resident or the medications to be diverted to an unknown recipient.</p> <p>Findings:</p> <p>During a telephone interview on 6/13/2024 at 11:43 a.m., Licensed Vocational Nurse 3 (LVN 3) stated on 6/8/2024 he came to work at 3 p.m. to 11 p.m. and he and Licensed Vocational Nurse 6 (LVN 6), who was the outgoing (7 a.m. to 3 p.m.) licensed nurse counted the individual controlled medications of the residents and checked the emergency medication kit inside the locked compartment of the medication cart. LVN 3 stated the emergency medication kit had been opened because it had a red tag on it. LVN 3 stated he and LVN 6 reconciled the contents of the emergency medication kit and identified there were 8 morphine tablets missing from the kit. LVN 3 stated there was no receipt in the kit to identify a resident who had needed an emergent dose of morphine nor a signature of the licensed staff who removed the 8 tablets of morphine. LVN 3 stated controlled medications including the emergency medication kit need to be reconciled before and after each shift to ensure there were no missing medications.</p> <p>During a telephone interview on 6/13/2024 at 12:45 p.m., Licensed Vocational Nurse 6 (LVN 6) stated it was the first time that she had to check the emergency medication kit in the locked compartment of the medication cart with another licensed nurse (LVN 3). LVN 6 stated whenever she counts the individual controlled medications of the residents with another licensed nurse, she and the licensed nurse never had to check the emergency medication kit at all. LVN 6 stated after counting the individual controlled medication of each resident, the incoming and outgoing licensed nurses sign the controlled log to confirm the controlled drug count was correct and the medications were stored safely.</p> <p>During a concurrent interview and record review on 6/13/2024 at 2:31 p.m., with the Director of Nursing Services (DON) the 3 (three) Controlled Sign in Sheets Logbook for Incoming and Outgoing Nurses from 6/1/2024 to 6/11/2024 was reviewed. The Logbooks indicated and the DON confirmed there were missing signatures and/or initials of licensed nurses from the 3 (three) Controlled Sign in Sheets Logbook for Incoming and Outgoing Nurses from 6/1/2024 to 6/11/2024, as indicated:</p> <p>a. Logbook 1= 5 (five) missing signatures</p> <p>b. Logbook 2= 6 (six) missing signatures</p> <p>c. Logbook 3= 18 (eighteen) missing signatures</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The DON stated it was the responsibility of each licensed nurse (whether incoming or outgoing licensed nurse) to ensure the emergency medication kit medications were accounted for before and after the shift to confirm safe storage, timely replacement, and prevention of accidental and/ or intentional loss of the controlled medications. The DON stated the licensed nurse must sign the Controlled Sign in Sheets to indicate the count of the controlled drugs, including the emergency kit, was done.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Medication Ordering and Receiving from Pharmacy updated 8/2020, the P/P indicated the facility's emergency medications which includes antibiotics, controlled substances and products for infusion must be contained in sealed containers and maintained at a designated area secured with a green seal, denoting the emergency box has not been opened and is intact. The P/P indicated the inventory count of the controlled medications must be updated and if the emergency kit has been opened (red tagged), the outgoing charge nurse must endorse the status of the emergency kit during shift change report for transfer of new medication orders and follow-up of replacement of the emergency kit.</p> <p>During a review of the facility's Policy and Procedure (P/P) on Medication Storage in the Facility updated 8/2019, the P/P indicated a controlled substance accountability record for all controlled medications, including those in the emergency supply must be completed upon dispensing or receipt of a controlled substance or use of a controlled substance from the emergency supply and at each shift, or when keys are transferred, a physical inventory of all controlled substances, including the emergency supply, is conducted by two licensed nurses and is documented.</p>		