| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055581 | A. Building<br>B. Wing | 03/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Jurupa Hills Post Acute | 6401 33rd Street.<br>Riverside, CA 92509 |

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

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>31524<br><br>Based on interviews, record review, facility policy review, and review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level 1 Assessment Guide, the facility failed to submit a status change to a level I PASRR following a new mental health diagnosis for 1 (Resident #58) of 5 sampled residents reviewed for PASRR requirements. Specifically, Resident #58 had a prior positive level 1 PASRR but was later diagnosed with a new mental health diagnosis, and the facility failed to submit a status change to the resident's level 1 PASRR evaluation.<br><br>Findings included:<br><br>A review of a facility policy titled, Admission Criteria PASARR, revised in March 2019, revealed, 9. All new admissions and readmissions are screened for mental disorders [MD], intellectual disabilities [ID] or related disorders [RD] per the Medicaid PASARR process. a. The facility conducts a level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD.<br><br>A review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level 1 Assessment Guide, dated 01/12/2023, revealed, The Level 1 Screening should always reflect the individual's current condition. We recommend checking if a Resident Review is needed during a facility's annual or quarterly MDS reviews.<br><br>A review of Resident #58's Admission Record revealed the facility admitted the resident on 06/18/2021 and most recently readmitted the resident on 10/12/2022. According to the Admission Record, the resident had a medical history that included schizophrenia, with an onset date of 06/18/2021, and anxiety, with an onset date of 01/10/2023.<br><br>A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Per the MDS, Resident #58 had active diagnoses that included anxiety disorder and schizophrenia and received antipsychotic and antianxiety medications in the seven days prior to assessment.<br><br>(continued on next page) |

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

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

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #58's Care Plan revealed a Focus area, initiated on 01/11/2023, that indicated the resident required an antianxiety medication for verbalized anxiety. Interventions directed staff to provide medication as ordered, to monitor for adverse side effects of the medication, and to promptly notify the physician if adverse side-effects were identified.<br><br>A review of Resident #58's Order Summary Report, listing active orders as of 03/26/2024, revealed orders for:<br><br>- buspirone hydrochloride (HCl) oral tablet, give 15 milligrams (mg) by mouth (po) two times a day (BID) for anxiety manifested by (m/b) verbalization of anxiety, started on 01/29/2024; and<br><br>- lorazepam oral tablet 1 mg, give 1 tablet po every 8 hours (Q8H) as needed (pro re nata, prn) for anxiety m/b verbalization of anxiety, started on 02/08/2024.<br><br>A review of Resident #58's medical record revealed a level I PASRR was completed on 07/07/2021. This level I PASRR was positive, and a Level II was submitted on 08/26/2021, which resulted in recommendations for specialized services. However, review of the resident's medical record revealed an updated PASRR was not completed after the resident received a new diagnosis of anxiety on 01/10/2023.<br><br>During an interview on 03/27/2024 at 11:08 AM, MDS Nurse #1 stated she submitted a new PASRR when a resident had a new psychiatric diagnosis and when she completed a significant change MDS. MDS Nurse #1 then stated Resident #58 should have had a new level I PASRR completed when they received the new diagnosis of anxiety on 01/10/2023.<br><br>During an interview on 03/27/2024 at 11:45 AM, MDS Nurse #2 stated a new level I PASRR was not completed when Resident #58 received a new diagnosis of anxiety on 01/10/2023.<br><br>During an interview on 03/29/2024 at 1:02 PM, the Director of Nursing (DON) stated she expected a new level I PASRR to be completed when a resident had a new psychiatric diagnosis.<br><br>During an interview on 03/29/2024 at 1:48 PM, the Administrator stated the level I PASRR was completed at the hospital for new admissions, but he did not know what needed to be done in relation to PASRRs when a resident received a new mental health diagnosis. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>41493<br><br>Based on interviews, record review, facility policy review, and review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level 1 Assessment Guide, the facility failed to ensure the accuracy of Level I PASRR screenings completed for 2 (Resident #12 and Resident #110) of 5 sampled residents reviewed for PASRR requirements.<br><br>Findings included:<br><br>A review of a facility policy titled, Admission Criteria PASARR, revised in March 2019, revealed, 9. All new admissions and readmissions are screened for mental disorders [MD], intellectual disabilities [ID] or related disorders [RD] per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD.<br><br>A review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level 1 Assessment Guide, dated 01/12/2023, revealed, Section III-Serious Mental Illness Questions 10-12 This section helps determine if the individual may have a serious mental illness and benefit from specialized services. Question 10. diagnosed Mental Illness *Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? *If yes, there will be a text box question [to] provide the type of mental illness.<br><br>1. A review of Resident #12's Admission Record revealed the facility admitted the resident on 10/06/2023 with diagnoses that included schizophrenia, major depressive disorder, and bipolar disorder.<br><br>A review of Resident #12's level I PASRR, dated 10/05/2023, revealed Section III - Serious Mental Illness - Definition, question #10, for whether the resident had a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disorder was answered, No. The level I PASRR screening was Negative and indicated a Level II evaluation was not required because the resident did not have a serious mental illness.<br><br>A review of Resident #12's Care Plan, revealed Focus areas, initiated on 10/06/2023, that indicated the resident used antidepressant medication for depression and antipsychotic medication for bipolar disorder and schizophrenia.<br><br>A review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/2023, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had severe cognitive impairment. Per the MDS, Resident #12 had active diagnoses that included schizophrenia, depression, non-Alzheimer's dementia, and bipolar disorder.<br><br>31524<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. A review of Resident #110's Admission Record revealed the facility admitted the resident on 01/19/2024 with diagnoses that included bipolar disorder, major depressive disorder, and anxiety disorder.<br><br>A review of Resident #110's level I PASRR, dated 01/19/2024, revealed Section III - Serious Mental Illness - Definition, question #10, for whether the resident had a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disorder was answered, No. The level I PASRR screening was Positive due to a suspected mental illness.<br><br>However, review of a letter from the California Department of Healthcare Services, dated 01/22/2024, revealed they were unable to complete a level II PASRR evaluation, because after reviewing the Level I PASRR screening dated 01/19/2024, the individual has no serious mental illness.<br><br>A review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/01/2024, revealed Resident #110 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Per the MDS, Resident #110 had active diagnoses that included anxiety disorder, depression, and bipolar disorder and received antipsychotic and antidepressant medications in the seven days prior to the assessment. According to the MDS, Resident #110 was not considered by the state level II PASRR process to have a serious mental illness and/or ID or a related condition.<br><br>A review of Resident #110's Care Plan revealed Focus areas, initiated on 02/13/2024, that indicated the residents used psychotropic medications related to bipolar disorder, antianxiety medications related to anxiety disorder, and antidepressant medication related to depression.<br><br>A review of Resident #110's Order Summary Report, listing active orders as of 03/26/2024, revealed orders for:<br><br>- Abilify oral tablet, give 5 milligrams (mg) by mouth (po) in the morning for bipolar manifested by (m/b) paranoia, started on 02/06/2024;<br><br>- lithium carbonate oral capsule 300 mg, give 2 capsules at bedtime (QHS) for bipolar disorder m/b mood swings, started on 01/19/2024; and<br><br>- trazodone hydrochloride (HCl) oral tablet 100 mg, give 1 tablet po QHS for depression m/b inability to sleep, started on 01/19/2024.<br><br>During an interview on 03/27/2024 at 11:08 AM, MDS Nurse #1 stated she did not know who checked the level I PASRRs completed at the hospital for accuracy.<br><br>During an interview on 03/27/2024 at 11:45 AM, MDS Nurse #2 stated no one had been checking level I PASRRs completed at the hospital for accuracy.<br><br>During an interview on 03/27/2024 at 1:31 PM, Marketer #13 stated she was responsible for ensuring new admissions had a level I PASRR completed. Marketer #13 further stated she looked through the PASRRs, but she was not a clinician, so she did not review them too thoroughly. Marketer #13 said the MDS nurses were responsible for ensuring PASRRs were complete and accurate.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 03/29/2024 at 1:02 PM, the Director of Nursing (DON) stated hospitals completed level I PASRRs for new admissions, and Marketer #13 was responsible for ensuring the facility obtained a copy of them. The DON then stated she expected facility staff to review clinical records to ensure PASRRs accurately reflected residents' clinical conditions and diagnoses.<br><br>During an interview on 03/29/2024 at 1:48 PM, the Administrator stated level I PASRRs were completed at the hospital for new admissions, and he expected them to accurately reflect each resident's status. |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193<br><br>Based on observations, interviews, record review, and facility document and policy review, the facility failed to implement a system that allowed staff to quickly and accurately identify code status (describes the type of interventions to be provided when an individual is found without a pulse or not breathing) in the event of an emergency and failed to honor the advance directive of 1 (Resident #32) of 4 sampled residents reviewed for advance directives. Specifically, on [DATE], staff initiated cardiopulmonary resuscitation (CPR) when Resident #32 was found unresponsive, despite the resident having a signed physician's order for life sustaining treatment (POLST) and an advance directive on file that indicated the resident elected do not resuscitate (DNR) in the event they were found not breathing or without a pulse. Resident #32 received CPR at the facility, endured painful resuscitation procedures, sustained injuries, was hospitalized , and expired in the hospital the following day.<br><br>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.24(a)(3) (Quality of Care) at a scope and severity of J.<br><br>The IJ began on [DATE] when Resident #32 received CPR from staff, dishonoring the resident's advance directive and physician-signed POLST form that specified DNR, resulting in injuries sustained during CPR procedures, hospitalization , and prolonged death until [DATE].<br><br>The Administrator and Director of Nursing (DON) were notified of the IJ and provided a copy of the IJ template on [DATE] at 6:43 PM. A removal plan was requested. The Removal Plan was accepted by the state survey agency on [DATE] at 8:49 PM. The IJ was removed on [DATE] at 4:03 PM, after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F678 remained at the lower scope and severity of G, actual harm.<br><br>Findings included:<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of a facility policy titled, Advance Directives, revised in [DATE], revealed, Advance directives will be respected in accordance with state law and facility policy. The policy indicated, 9. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The policy further indicated, 14. In accordance with current OBRA [Omnibus Budget Reconciliation Act] definitions and guidelines governing advance directives, our facility has defined advanced [sic] directives as preferences regarding treatment options and include, but are not limited to: a. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by State law, relating to the provisions of health care when the individual is incapacitated, e. Do Not Resuscitate - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used, and h. Life-Sustaining Treatment - treatment that, based on reasonable medical judgement, sustains an individual's life and without it the individual will die. This includes medications and interventions that are considered life-sustaining, but not those that are considered palliative or comfort measures.<br><br>A review of a facility policy titled, Do Not Resuscitate Order, revised in [DATE], revealed, Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. Policy Interpretation and Implementation 1. Do not resuscitate orders must be signed by the resident's Attending Physician on the physician's order sheet maintained in the resident's medical record. 2. A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State law) and placed in the front of the resident's medical record, 3. In addition to the advance directive and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include: a. Physician Orders for Life-Sustaining Treatment (POLST). The policy further specified, 5. Do not resuscitate (DNR) orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. a. Verbal orders to cease the DNR will be permitted when two (2) staff members witness such request. b. Both witnesses must have heard the request, and both individuals must document such information on the physician's order sheet. c. The Attending physician must be informed of the resident's request to cease the DNR order.<br><br>A review of Resident #32's Admission Record revealed the facility admitted the resident on [DATE] and most recently readmitted the resident on [DATE] with diagnoses that included unspecified symptoms and signs involving cognitive functions following a cerebral infarction (stroke), type two diabetes mellitus, essential hypertension, hyperlipidemia (high cholesterol), and unspecified severe protein-calorie malnutrition. The section of the Admission Record for Advance Directive information was blank.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of a POLST form, dated [DATE] and signed by a physician and Resident #32, revealed that at the time of admission, Resident #32's POLST specified, If patient has no pulse and is not breathing, Attempt Resuscitation/CPR. The Form also included, the following guidance, Reviewing POLST: It is recommended that POLST be reviewed periodically. Review is recommended when: -The patient is transferred from one care setting or care level to another, or -There is substantial change in patient's health status, or -The patient's treatment preferences change. Modifying and voiding POLST: -A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke it. It is recommended that revocation be documented by drawing a line through Sections A through D, writing VOID in large letters, and signing and dating this line. -A legally recognized decision maker may request to modify orders, in collaboration with the physician/NP [nurse practitioner]/PA [physician's assistant], based on the known desires of the patient, or, if unknown, the patient's best interests.<br><br>A review of Resident #32's California Advance Health Care Directive, dated [DATE], notarized and signed by the resident and the resident's power of attorney (POA), indicated a Choice NOT To Prolong Life: I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.<br><br>On [DATE] at 3:50 PM, a review of Station #2 and Station #3's POLST book, revealed a more recent copy of a POLST form for Resident #32, dated [DATE] and signed by a physician and Resident #32's POA. Resident #32's [DATE] POLST indicated, If patient has no pulse and is not breathing, Do Not Attempt Resuscitation/DNR. (Allow Natural Death).<br><br>A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #32 had a Brief Interview of Mental Status (BIMS) score of 3, indicating the resident had severe cognitive impairment. Section S of the MDS, related to POLST and code status, was not completed.<br><br>A review of Resident #32's comprehensive Care Plan revealed there were no Focus areas or interventions related to the resident's end of life wishes. There was, however, a Focus area, initiated on [DATE], that indicated the resident required transfer to an acute care setting due to being unresponsive, and the resident's condition was unable to be managed in the facility. An intervention directed staff to send a copy of the resident's code status/POLST to the acute care facility.<br><br>A review of Resident #32's Order Summary Report, listing active orders as of [DATE], revealed an order dated [DATE] for DNR.<br><br>A review of Resident #32's Progress Notes revealed the following entries:<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - a Change of Condition note, dated [DATE] at 1:51 PM that indicated Resident #32 yelled Help at 1:20 PM. Per the note, a registered nurse (RN) went in right away and found the resident unresponsive, and a Full code was confirmed and a Code Blue was paged overhead. The note further indicated no respirations or heartrate were found. According to the note, CPR was initiated, the resident's blood sugar was checked, suctioning was performed, and the physician was notified. Per the note, at 1:24 PM, a pulse was felt, but the resident remained unresponsive, and after ongoing CPR, at 1:27 PM, staff were unable to obtain a pulse, respiratory rate, or blood pressure. Intravenous (IV) fluids were given, and paramedics arrived at 1:32 PM and took over CPR. The note indicated that at 1:38 PM, 18 minutes after calling the code, the nurse notified Resident #32's POA, and the POA agreed to Full code CPR. The paramedics and fire department continued CPR and transported Resident #32 to a local hospital at 1:57 PM; and<br><br>- a Nurse's Note documented by Registered Nurse (RN) #9, dated [DATE] at 2:31 PM, that indicated at 1:20 PM, the resident called out for help, and RN #9 responded and found the resident on the bed with their eyes open and breathing, but unresponsive. Per the note, the resident's pulse was initially 75 beats per minute and their oxygen saturation was 100 percent (%), but the resident suddenly stopped breathing and had no pulse. The note further indicated a code blue was initiated, 911 was called, and CPR was initiated.<br><br>A review of Resident #32's hospital record revealed an HPI [History of Present Illness]- General Illness note, dated [DATE] at 2:38 PM, that indicated Resident #32 was found unresponsive and pulseless, and CPR was initiated. Per the note, emergency medical services (EMS) reported that upon arrival at the skilled nursing facility, Resident #32 was found to be in ventricular fibrillation (VFib) arrest (when the lower heart chambers contract in a very rapid and uncontrolled manner, resulting in no blood pumped to the rest of the body). The note indicated CPR was performed for around 25 minutes, in conjunction with four rounds of epinephrine and four rounds of shock. The note indicated that on [DATE] at 3:50 PM, upon a Physical Exam, Resident #32 was intubated, pulseless, and on a vent, bilateral breath sounds present. The note further indicated, On arrival [to the hospital], patient lost pulses so CPR was restarted. Patient was intermittently going into Vtach [ventricular tachycardia], therefore patient given one more round of shock. The note also detailed conversations with Resident #32's POA regarding the resident's end of life wishes. The note indicated Resident #32's POA reported to the hospital that the resident told them many times that they wanted to be DNR, but the paperwork was not completed, and the current paperwork reflected the resident was a full code. Per the note, the POA requested the hospital place the resident on hospice care with no further workup or treatment at this time and wants to focus on comfort care.<br><br>On [DATE] at 9:21 AM, a phone call was placed to Resident #32's POA. A voicemail was left, but no return call was received.<br><br>A review of computed tomography (CT) results, performed in the hospital on [DATE], revealed the IMPRESSION included, 5. Acute, nondisplaced fracture of right anterolateral 2nd rib. Acute, mildly displaced fractures of the right anterior 2nd-5th ribs at the costochondral junction. 6. Acute, displaced fractures of the left anterior 3rd-6th ribs. 7. Suspected acute nondisplaced sternal fracture. Findings are most likely due to chest compressions.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of a hospital Multidisciplinary Team Note, dated [DATE] at 4:14 PM, revealed, Patient extubated at 1614 [4:14 PM]. Patient subsequently went agonal and asystole on the monitor. Per the note, asystole and no pulse were verified by two nurses, and a physician was notified. Resident #32's time of death was [DATE] at 4:25 PM.<br><br>A review of Resident #32's deceased Discharge Summary, dated [DATE] at 4:42 PM, revealed, Preliminary cause of death included VFib cardiac arrest status post ROSC [return of spontaneous circulation] and Acute hypoxic respiratory failure status post intubation on mechanical ventilation.<br><br>During an interview on [DATE] at 8:35 AM, RN #9 stated she was the nurse that performed CPR on Resident #32. She stated she was sitting at the nurse's station and heard the resident call for help. When she went to the room, the resident's eyes were open, but the resident did not respond. According to RN #9, Licensed Vocational Nurse (LVN) #5 and MDS Nurse #2 were at the nurse's station at the time. RN #9 said she told LVN #5 to call a code blue. Per RN #9, MDS Nurse #2 looked in the POLST book at the nurse's station and could not find Resident #32's POLST, so she used the POLST that was scanned into the resident's electronic health record (EHR), which indicated Resident #32 was a full code. RN #9 stated the paramedics arrived and were given a copy of the POLST printed off the computer that indicated the resident was a full code. RN #9 could not recall the date on the POLST form they pulled from the computer and subsequently provided to the paramedics, but she confirmed the document indicated Resident #32 was to be a full code.<br><br>During an interview on [DATE] at 12:53 PM, LVN #5 stated she was at the nurse's station and heard Resident #32 scream for help. Per LVN #5, RN #9 went to check on the resident and told LVN #5 to call a code blue and to check the resident's POLST. RN #9 said when she and MDS Nurse #2 located a POLST that indicated full code, CPR was initiated and 911 was contacted. LVN #5 stated she was the one that called Resident #32's POA and informed them facility staff were performing chest compressions, and the POA agreed to continue them.<br><br>During an interview on [DATE] at 7:41 AM, MDS Nurse #2 stated she was the on-call nurse and was at the nurse's station at the time of Resident #32's code. She stated RN #9 called out for a code blue. According to MDS Nurse #2, Resident #32 had a POLST that reflected full code, so CPR was initiated. MDS Nurse #2 said a copy of the POLST reflecting full code was given to EMS, and they continued the code as the resident was leaving the facility to go to the hospital. During the interview, MDS Nurse #2 was shown a copy of Resident #32's POLST dated [DATE] that reflected the resident was to be DNR. MDS Nurse #2 said she was shocked and did not know what happened. MDS Nurse #2 then looked in the POLST book, which was present in the office at the time of the interview, and verified Resident #32's POLST form was no longer in the book. MDS Nurse #2 then walked with this surveyor to the Medical Records office to see where Resident #32's POLST form was located.<br><br>During an interview on [DATE] at 8:04 AM, the Medical Records Director (MRD) stated the process for POLST forms was for the admissions department and social services to get a POLST completed and signed upon admission, if the resident did not currently have one in place. The POLST was then given to the physician for signature, and once signed, medical records uploaded the form into the resident's EHR and placed the original in the POLST book.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 8:08 AM, the Medical Records Assistant (MRA) stated that when a new POLST form was completed and signed, it should be placed in the POLST book, and scanned into the EHR. The MRA provided Resident #32's [DATE] POLST form indicating DNR and stated she pulled it from the POLST book that morning, [DATE], due to the resident no longer being in the facility.<br><br>During an interview on [DATE] at 7:36 AM, the Director of Nursing (DON) reviewed Resident #32's EHR and said the POLST completed in 2016 (reflecting full code) was the only one available. The surveyor then showed the DON a copy of the [DATE] POLST reflecting the resident had elected DNR and informed her the copy was located in the POLST book at the nurse's station on [DATE]. The DON said that when a POLST form was completed and signed, medical records staff should scan a copy into the EHR and place the form in the POLST book. The DON further stated that a code status order should be transcribed into the EHR so that it would be listed in the EHR in the same area resident allergies were listed. She indicated this allowed for ease of access to that pertinent information. The DON said that if there were residents who did not have a POLST available, then evidently the staff were not following through with the process correctly.<br><br>A review of Resident #32's EHR revealed no code status was reflected in the area where the resident's allergies were listed, as the DON indicated it should be.<br><br>During a subsequent interview on [DATE] at 10:26 AM, the DON stated the breakdown in the process for Resident #32's code was that the facility was converting from paper charts to all EHR over the prior weekend. According to the DON, Resident #32's chart was one that still had documents that needed to be scanned. She further stated the resident's POLST dated [DATE] must have been in the resident's old chart and a copy was not placed in the POLST book by medical records staff when it was signed three years ago. The DON said the previous POLST from 2016 that reflected full code was in the POLST book at the time of Resident #32's code. Per the DON, Resident #32's paper chart was disassembled over the prior weekend, and on Monday, [DATE], medical records staff placed the POLST from 2021 that indicated DNR into the POLST book at the nurse's station, which is why the surveyor was able to view it on Tuesday, [DATE]. The DON confirmed that for the past three years, Resident #32 desired to be DNR, but a copy of their prior POLST reflecting full code was in the POLST book instead.<br><br>During an interview on [DATE] at 9:58 AM, the Administrator stated he understood there were two issues that needed addressed: the POLST process was broken, and the CPR event with Resident #32. The Administrator said at the time of the code, Resident #32's [DATE] POLST that showed the resident was a full code was the one available to staff. The Administrator further stated the resident's current POLST, dated [DATE], that reflected the resident's DNR status was located in a physical chart in medical records in the back of the facility, not readily accessible to staff during the code. The Administrator said the POLST should not have been located in the physical chart because the facility no longer used physical charts and indicated the form should have been in the POLST book instead. The Administrator stated that when staff were looking for a code status, they should first look in the EHR, and secondarily or simultaneously look in the POLST book to identify a resident's code status.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 1:26 PM, the DON stated her expectations for the POLST and advance directives process was that upon admission the staff would ask the resident or their responsible party what their wishes were. A POLST should then be completed and signed, and a copy scanned into the EHR. The DON said a nurse would then input the code status order into the EHR. The DON said she wanted her end of life wishes to be respected and her decisions to be followed, and she wanted that for others as well. The DON said the failure to honor a resident's advance directive or POLST was not only not honoring their wishes but also a life and death decision.<br><br>During an interview on [DATE] at 2:17 PM, the Administrator stated he expected staff to implement residents' advance directives and POLSTs in the event of an emergency. He stated he expected staff to be able to locate the POLST and to understand the importance of checking them in the event of an emergency. The Administrator further stated it was important to honor a resident's advance directive because it was their wishes and a resident's right.<br><br>During an interview on [DATE] at 10:37 AM, the Medical Director stated he expected staff to complete POLSTs and advanced directives thoroughly, obtain the appropriate signatures, and to always honor and follow each resident's wishes.<br><br>On [DATE] at 8:49 PM, a Removal Plan was submitted by the facility and accepted by the state survey agency. It read as follows:<br><br>1. Medical Records on [DATE] will conduct a facility wide audit to determine if all residents have the code status uploaded into the electronic health records of the resident's chart.<br><br>2. A list of Residents that are identified by Medical Records as to not having a POLST will be given to Social Services, Case Manager, and Director of Nursing. Social Services will inquire if the residents want to complete a POLST form with the resident's corresponding facility Physician. Residents that refuse to sign a POLST will be considered full code unless their advance directive says otherwise. This will be completed on [DATE].<br><br>3. Medical Records staff will remove the POLST binder from the nursing station and Medical Records will provide each Resident with a physical chart containing the face sheet, the signed POLST, and the personal inventory of the resident. This will be completed on [DATE].<br><br>4. The Director of Nursing (DON) and designee conducted an in-service to Licensed Nurses and Department Heads during their shift on [DATE] and [DATE]. The in-service was about the location of the code status of the resident which is made available on the resident's physical chart as well as on the scanned documents of the resident's electronic health record. Every nurse will be in-serviced in person or through a phone call on [DATE]. DON will check off each nurse to ensure completion. Twenty-Eight licensed vocational nurses (LVNs) and seven registered nurses (RNs) will be in-serviced prior to working their shift.<br><br>5. DON and Administrator conducted an in-service with Medical Records Staff on [DATE] on the importance of uploading signed POLST forms in the resident's electronic health record within 72 hours of admission and providing each Resident with a physical chart containing the face sheet, the signed POLST, and the personal inventory of the resident.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 6. The DON conducted an in-service with the interdisciplinary team (IDT) on [DATE]. After a care conference with the resident or the responsible party, and when the POLST is confirmed, the IDT will verify if the POLST is available in the resident's electronic health record and will notify Medical Records Staff accordingly. Care conferences are completed within 14 days of admitting to the facility, quarterly, annually, and when there is a significant change of condition.<br><br>7. Medical Records Staff will conduct audits for newly admitted and readmitted residents to ensure POLST forms are uploaded in the electronic heath record of the resident's chart and available in the resident's physical chart. This will be done within 72 hours of admission.<br><br>8. Medical Records Staff will conduct twice a week audit of all the nursing stations to ensure POLST forms are uploaded in the electronic health record of the resident's chart and available in the resident's physical chart. This will be done twice a week for 3 months, and then weekly after indefinitely.<br><br>9. The Administrator notified the facility Medical Director of this recent survey findings, and he will conduct a follow up in-service with the Licensed Nurses (Twenty - Eight licensed vocational nurses (LVNs) and seven registered nurses (RNs)), on [DATE]. All AM/PM shifts will be present. The in-service will be recorded and sent to the nurses that cannot be present. This will be done by [DATE].<br><br>10. Newly hired Licensed Nurses and IDT will be oriented by the Director of Staff Development (DSD) or designee on where to locate the Code Status of the residents which are on the electronic health record or the resident's chart and available in the resident's physical chart. This will be completed on the day of orientation.<br><br>11. The DON will conduct monthly in-services to licensed nurses for 3 months on where to locate the code status of the resident which is made available on the resident's physical chart as well as on the scanned documents of the resident's electronic health record. The POLST is located in the documents tab on the electronic health record.<br><br>12. Medical Records Director will report during monthly QA meeting the findings of the audits on POLST and Quality Assurance (QA) committee will monitor trends. This will be done for 3 months.<br><br>13. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was conducted on [DATE]. This meeting was to discuss the IJ findings and to develop a plan to get it removed. The Director of Nursing, Administrator, and Medical Records Director attended.<br><br>Per the facility, all immediate corrective actions would be completed by [DATE].<br><br>Onsite Verification:<br><br>The IJ was removed on [DATE] at 4:03 PM, after the survey team verified the implementation of the Removal Plan as follows:<br><br>1. Medical Records audits were reviewed for completion with spot checks done to ensure each resident had a POLST uploaded into their EHR.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. Review of the residents identified as not having a POLST consisted of one resident, who was not able to make the decision themselves. Multiple calls were placed to their responsible party (RP) without a response. Until a signed POLST is obtained, the resident will remain a full code. Facility staff will continue to reach out to the RP.<br><br>3. Nurse's stations were checked with verification of each resident having their own chart containing their POLST, face sheet, and personal inventory.<br><br>4. The in-service conducted by the DON was reviewed for content along with the sign in sheet to ensure nurses were being in-serviced prior to their next shift if not in the building during the in-service. Nurses and Department Heads were interviewed to ensure they received the in-service and questions were asked to ensure they understood the processes.<br><br>5. Inservice Training Reports were reviewed for content. Interviews with Medical Records staff revealed an understanding of the process and their role in ensuring the POLST is available to staff for review.<br><br>6. The Inservice Training Report was reviewed and revealed the interdisciplinary team (IDT) was inserviced on the POLST process. Members of the IDT were interviewed regarding their knowledge of the process and their role in the process.<br><br>7. The audit form to be used by Medical Records for admissions going forward was reviewed for content.<br><br>8. The audit form to be used for the twice a week audit of the POLST forms was reviewed for content.<br><br>9. The Inservice Training Report for the education provided by the Medical Director was reviewed, as well as all the content of the education. Attendance signatures were reviewed. An interview was conducted with the Medical Director on [DATE] at 10:37 AM. The Medical Director confirmed he had educated staff regarding POLSTs, including completing each section thoroughly, ensuring all sections were signed, and his expectations for staff to honor POLST and advance directive wishes. The Medical Director also stated he discussed multiple scenarios with staff while providing the education, and staff interacted and asked pertinent questions.<br><br>10. The Inservice Training Report for the education provided to the DSD regarding newly hired nurses was reviewed. The material used to orient new nurses was reviewed with the DSD and an interview was completed to ensure she understood her role in the process of obtaining and honoring POLSTs and advance directives.<br><br>11. The in-service to be conducted monthly by the DON was reviewed for content, and the DON was interviewed on her role in the process of ensuring POLSTs and advance directives are honored by staff. Dates for the next three monthly in-services were supplied.<br><br>12. The Medical Records Director was interviewed on [DATE] at 8:23 AM regarding her role in the process. She was able to verbalize the process and indicated she would report audit findings during QA meetings each month.<br><br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 13. The Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting's signature page was reviewed. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>31524<br><br>Based on interviews, record review, and facility policy review, the facility failed to ensure the resident's medication regimen was free from unnecessary medications for 1 (Resident #58) of 5 sampled residents reviewed for unnecessary medications. Specifically, Resident #58 had an order for lorazepam (a benzodiazepine that may be used to treat anxiety) that was started on 02/08/2024 with no stop date or re-evaluation for continued use.<br><br>Findings included:<br><br>A review of a facility policy titled Psychotropic Medication Use, revised in July 2022, revealed, Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The policy revealed 14. PRN [pro re nata; as needed] orders for psychotropic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order.<br><br>A review of Resident #58's Admission Record revealed the facility admitted the resident on 06/18/2021. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and anxiety.<br><br>A review of Resident #58's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Per the MDS, Resident #58 had diagnoses of anxiety and schizophrenia and received an antipsychotic and antianxiety medication in the seven days prior to the assessment.<br><br>A review of Resident #58's Care Plan revealed a Focus statement initiated on 01/11/2023 that indicated the resident needed antianxiety medication due to anxiety manifested by verbalization of anxiousness. Interventions directed staff to provide medication as ordered, to monitor for adverse side effects of medication, and to promptly notify the physician.<br><br>A review of Resident #58's Order Summary Report, with active orders as of 03/26/2024, revealed an order with a start date of 02/08/2024 for lorazepam oral tablet 1 mg, give one tablet by mouth every eight hours as needed for anxiety manifested by verbalization of anxiety. Further review revealed there was no stop date or duration included in the order.<br><br>A review of Resident #58's February 2024 Medication Administration Record [MAR] revealed the transcription of an order started on 02/08/2024 for lorazepam oral tablet 1 mg, give one tablet by mouth every eight hours as needed for anxiety manifested by verbalization of anxiety. Further review revealed the medication was documented as administered on 02/16/2024, 02/20/2024, and 02/24/2024.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #58's March 2024 MAR revealed the transcription of an order started on 02/08/2024 for lorazepam oral tablet 1 mg, give one tablet by mouth every eight hours as needed for anxiety manifested by verbalization of anxiety. Further review revealed no documentation that the medication was administered for the timeframe from 03/01/2024 to 03/25/2024.<br><br>During an interview on 03/27/2024 at 2:18 PM, the Pharmacist stated he expected the facility to follow the Centers for Medicare and Medicaid Services (CMS) requirements for the use of PRN psychotropic medications where residents needed to be re-evaluated after 14 days for the continued use of a PRN psychotropic.<br><br>During an interview on 03/29/2024 at 1:02 PM, the Director of Nursing (DON) stated that the use of PRN psychotropics had to be re-evaluated after 14 days to prevent unnecessary medications. The DON further stated that a practitioner's re-evaluation was needed to determine if the resident needed the medication administered routinely or if it was not given, to then discontinue the PRN order.<br><br>During an interview on 03/29/2024 at 1:48 PM, the Administrator stated he expected medications to be administered within the specified time frames, and he was not familiar with any regulations related to the PRN use of psychotropics. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>31524<br><br>Based on interviews, record review, and facility policy review, the facility failed to follow vital sign parameters when administering medications for 1 (Resident #58) of 5 sampled residents reviewed for unnecessary medications. Specifically, facility staff failed to hold medications when Resident #58's Systolic Blood Pressure (SBP) was less than (<) 110 millimeters of mercury (mmHg) as outlined in the physician's order.<br><br>Findings included:<br><br>A review of a facility policy titled Administering Medications, revised in April 2019, revealed, Medications are administered in a safe and timely manner, and as prescribed. The policy revealed, 4. Medications are administered in accordance with prescriber orders. Further review revealed, 11. The following information is checked/verified for each resident prior to administering medications: b. vital signs, if necessary.<br><br>A review of Resident #58's Admission Record revealed the facility admitted the resident on 06/18/2021. According to the Admission Record, the resident had a medical history that included diagnoses of hypertension and heart failure.<br><br>A review of Resident #58's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Per the MDS, Resident #58 had diagnoses of heart failure and hypertension.<br><br>A review of Resident #58's Care Plan revealed a Focus statement initiated on 10/19/2022 that indicated the resident had a diagnosis of hypertension. Interventions included to give anti-hypertensive medications as ordered, to monitor for side effects such as orthostatic hypotension, increased heart rate, and effectiveness, and to obtain blood pressure readings under the same conditions each time. Further review revealed a Focus statement initiated on 01/15/2024 that indicated the resident received treatment for cardiac insufficiency related to heart failure. Interventions directed staff to give medication as ordered.<br><br>A review of Resident #58's Order Summary Report with active orders as of 03/26/2024 revealed an order with a start date of 12/10/2022 for amiodarone hydrochloride (HCl) (an anti-arrhythmic drug used to treat an irregular heartbeat) tablet 200 milligrams (mg), give one tablet by mouth two times a day for atrial flutter, hold if heart rate (HR) < 60 beats per minute (bpm) or SBP < 110 mmHg.<br><br>A review of Resident #58's February 2024 Medication Administration Record [MAR] revealed the transcription of an order with a start date of 12/10/2022 for amiodarone HCl tablet 200 mg, give one tablet by mouth two times a day for atrial flutter, hold if HR < 60 bpm or SBP < 110 mmHg. The MAR revealed the medication was documented as administered six times in February 2024 when Resident #58's SBP was less than 110 mmHg.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #58's March 2024 MAR revealed the transcription of an order with a start date of 12/10/2022 for amiodarone HCl tablet 200 mg, give one tablet by mouth two times a day for atrial flutter, hold if HR < 60 bpm or SBP < 110 mmHg. The MAR revealed that during the timeframe from 03/01/2024 to 03/25/2024, the medication was documented as administered six times when Resident #58's SBP was less than 110 mmHg.<br><br>During an interview on 03/27/2024 at 9:35 AM, Licensed Vocational Nurse (LVN) #3 stated it was important to hold medication if the resident's vital signs were below the parameters because it would put the resident at risk of hypotension or other issues. LVN #3 confirmed he was one of the nurses who documented on the February 2024 and March 2024 MAR that he had administered amiodarone to Resident #58 when their SBP was less than 110 mmHg. LVN #3 stated it must have been a click error because he would not have administered the medication to Resident #58 if their SBP was less than 110 mmHg.<br><br>During an interview on 03/27/2024 at 10:02 AM, Physician #4 stated following vital sign parameters was very important because if a resident's blood pressure was already lower than normal and a nurse administered a medication that affected vital signs, the resident could become severely hypotensive, it could cause dizziness, the resident could pass out, and have other issues. Physician #4 further stated amiodarone controlled the heart rhythm, and in looking at Resident #58's vital signs on the days the nursing staff documented they administered the medication, Physician #4 stated he would have expected staff to have held the medication because Resident #58's blood pressure was already within the resident's normal limits. Physician #4 stated administering the amiodarone to Resident #58 with a low SBP could cause the SBP to lower even more and put the resident at risk for adverse events.<br><br>During an interview on 03/27/2024 at 11:48 AM, LVN #5 stated that when vital sign parameters were included with an order for a heart medication, she held the medication if a resident's SBP was less than 110 mmHg. During the interview, LVN #5 reviewed the February 2024 and March 2024 MAR and stated that she did not know why it was documented that she administered amiodarone to Resident #58 when their SBP was less than 110 mmHg.<br><br>During an interview on 03/29/2024 at 1:02 PM, the Director of Nursing (DON) stated she expected the nursing staff to take vital signs prior to administering medications and to hold certain medications if it was indicated to do so when their SBP was outside of the indicated parameters. The DON further stated it was important to follow vital sign parameters when administering medications to prevent any negative effects to the resident.<br><br>During an interview on 03/29/2024 at 1:48 PM, the Administrator stated he expected the nursing staff to administer medications based on the physician's orders, and that it was important to do so to keep the residents safe and comfortable, and to help them get better. |

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|---|---|---|---|
| | 055581 | A. Building<br>B. Wing | 03/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Jurupa Hills Post Acute | 6401 33rd Street.<br>Riverside, CA 92509 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>35314<br><br>Based on observations, interviews, and facility policy review, the facility failed to ensure food was prepared and served in a manner to prevent potential cross contamination. Specifically, staff failed to utilize a beard restraint while preparing drinks for meal service, and another staff member failed to wash their hands and change gloves when leaving the meal service line to prepare a quesadilla. These failures had the potential to affect 125 of 125 residents who received meals from the dietary department.<br><br>Findings included:<br><br>A review of a facility policy titled, Dress Code, dated 2023, revealed PROPER DRESS included, 8. If applicable, beards and mustaches (any facial hair) must wear beard restraint.<br><br>On 03/26/2024 at 11:19 AM, Cook #6 was observed working in the kitchen with a full beard. Cook #6 did not wear a beard restraint. Cook #6 was observed preparing drinks for the lunch meal service. He completed the lunch meal service without wearing a beard restraint.<br><br>During an interview on 03/26/2024 at 1:44 PM, Cook #6 stated it was the expectation of the facility that dietary staff wore hair restraints before entering the kitchen. He stated not wearing beard restraints could result in cross contamination and hair in residents' food. Cook #6 confirmed he did not wear a beard restraint on 03/26/2024 during meal service. Cook #6 further stated the Dietary Director told him earlier that morning to wear a beard restraint, but he was busy and forgot to wear one.<br><br>During an interview on 03/27/2024 at 1:52 PM, the Dietary Director stated she expected staff to restrain all hair before entering the kitchen. The Dietary Director further stated the facility had beard restraints available for staff use and indicated she spoke with Cook #6 previously about wearing a beard restraint.<br><br>A review of a facility policy titled, Food Preparation and Service, revised in November 2022, revealed, Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use.<br><br>On 03/26/2024 beginning at 11:43 AM, Cook #7 was observed plating food during the lunch meal service. At 11:51 AM, Cook #7 turned away from the meal service line and used a spatula to flip a quesadilla on the grill. Cook #7 did not wash hands or change gloves between tasks.<br><br>During an interview on 03/26/2024 at 1:25 PM, with Dietary Aide #8 translating, Cook #7 revealed he must change gloves when he changed tasks.<br><br>During an interview on 03/29/2024 at 1:00 PM, the Director of Nursing (DON) stated when staff were in the kitchen, they must wear hairnets or covers, including beard covers, if applicable. The DON further stated dietary staff should change gloves between tasks.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 03/29/2024 at 1:48 PM, the Administrator stated staff should wear hair restraints when in the kitchen and change gloves between tasks. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>35314<br><br>Based on interviews, record review, and facility policy review, the facility failed to maintain medical records that were accurately documented for 1 (Resident #31) of 5 sampled residents reviewed for unnecessary medications.<br><br>Findings included:<br><br>A review of a facility policy titled Psychotropic Medication Use, revised in July 2022, revealed, 6. Diagnosis of a specific condition for which psychotropic medications are necessary to treat will be based on a comprehensive assessment of the resident. The policy revealed, 8. Resident diagnosis is based on a comprehensive assessment and evidence-based criteria and is consistent with professional standards.<br><br>A review of Resident #31's Admission Record revealed the facility admitted the resident on 07/07/2023. According to the Admission Record, Resident # 31 was diagnosed with schizophrenia on 10/23/2023.<br><br>A review of Resident #31's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/20/2024, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #31 had no behaviors during the assessment period. Per the MDS, Resident #31 had a diagnosis of schizophrenia.<br><br>A review of Resident #31's Care Plan revealed a Focus statement initiated on 01/29/2024 that indicated the resident used a psychotropic medication (Seroquel) related to a diagnosis of schizophrenia. Interventions directed staff to administer medications as ordered and consult with the pharmacy and medical doctor to consider dosage reduction when clinically appropriate.<br><br>A review of an Informed Consent- Psychoactive Medication form dated 03/12/2024 revealed Resident # 31 had been prescribed Seroquel 50 milligram (mg), with schizophrenia being the indication for use.<br><br>A review of Resident #31's Medication Administration Record [MAR] for the timeframe from 03/01/2024 to 03/36/2024 revealed a transcription of an order with a start date of 10/23/2023 for Seroquel oral tablet 50 mg, give 50 mg by mouth at bedtime for schizophrenia manifested by paranoia and visual hallucinations.<br><br>A review of the Consultant Pharmacist Recommendations dated 10/24/2023 for Resident #31 revealed, 2. Please contact the physician or psychiatrist to clarify the diagnosis for use of antipsychotic drug Seroquel. Medicare (CMS) [Center for Medicare and Medicaid Services] requires that we identify specific reasons and diagnoses for the use of antipsychotic drugs. Under CMS's regulations, skilled nursing residents may receive antipsychotic drugs only [sic] the following diagnoses:<br><br>-Schizophrenia<br><br>-Schizoaffective disorder<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Bipolar Disorder<br><br>-Depression (i.e. [id est, that is] refractory or adjunct therapy)<br><br>-Post-Traumatic Stress Disorder<br><br>-Huntington's Disease<br><br>-Tourette syndrome<br><br>-Psychosis<br><br>A review of Resident #31's Psychiatry Follow Up Note dated 10/23/2023 revealed, under the section titled General Comments, Seroquel 25 mg HS [at bedtime] not managing psychosis affecting sleep. The note revealed, under the section titled Plan and Recommendations, Medication Changes: increase Seroquel from 25 to 50 mg HS. Further review revealed no documentation of a diagnosis of schizophrenia.<br><br>A review of a form titled View Diagnosis for Resident #31 revealed that a diagnosis of schizophrenia dated 10/23/2023 was created on 01/29/2024 by MDS Nurse #1.<br><br>During an interview on 03/27/2024 at 7:29 AM, MDS Nurse #1 stated that residents with a new diagnosis of schizophrenia were evaluated by a psychologist; the facility did not diagnose the residents, but the psychologist did and placed the diagnosis on the visit notes. MDS Nurse #1 stated she reviewed the orders and ensured the medications matched the diagnosis.<br><br>During an additional interview with MDS Nurse #1 on 03/27/2024 at 9:07 AM, MDS Nurse #1 stated it was a mistake made by her that the diagnosis of schizophrenia was entered into Resident #31's medical record. She stated the MDS, the resident care plan, and the order for Seroquel had been updated following the surveyor's inquiry. MDS Nurse #1 stated she thought one of Resident #31's psychiatry notes reflected the diagnosis, and after further review, she found out she was wrong. She stated the coding for schizophrenia and psychosis were closely related, and she documented schizophrenia in error.<br><br>During an interview on 03/27/2024 at 2:18 PM, the Pharmacist Consultant stated he followed CMS and Title 22 (California Code of Regulations) guidelines when reviewing antipsychotic medication use. He stated Resident #31 was placed on Seroquel in September of 2023. He stated that he provided pharmacy recommendations for October of 2023 that reflected there must be a diagnosis for the continued use of the medication. The Pharmacist Consultant stated shortly afterward, the facility provided him with a diagnosis of schizophrenia for Resident #31. He stated that he did not know where the diagnosis came from; he saw the diagnosis on the report and did not question the report.<br><br>During an interview on 03/28/2024 at 1:08 PM, the Psychiatric Mental Health Nurse Practitioner (PMHNP) stated Resident #31 did not have a diagnosis of schizophrenia. The PMHNP stated Resident #31 had never been diagnosed with schizophrenia; the resident should be taking Seroquel for psychosis related to Parkinson's Disease.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/29/2024 at 1:00 PM, the Director of Nursing (DON) stated the residents must have the appropriate diagnosis. The DON stated for the residents to receive a diagnosis of schizophrenia, they must have the indications, and they must have a psychiatry evaluation completed that reflected that diagnosis. The DON stated the facility should not document a diagnosis in the resident's medical records if a physician had not diagnosed the resident.<br><br>During an interview on 03/29/2024 at 1:48 PM, the Administrator stated it was his expectation that a resident's diagnosis was accurate. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41493<br><br>Based on observations, interviews, record reviews, and facility document and policy review, the facility failed to test staff identified via contact tracing as having a high-risk COVID-19 exposure. This had the potential to affect all residents who resided in the facility. Additionally, the facility failed to ensure that perineal care was performed in a sanitary manner for 1 (Resident #51) of 1 resident observed during perineal care.<br><br>Findings included:<br><br>1. A review of a facility policy titled Coronavirus Disease (COVID-19) Policy on Surveillance, Testing, Reporting, Management and Staffing Guidance, revised in December 2023, revealed, Screening and Monitoring: 1. The Infection Preventionist is responsible for establishing and overseeing the active screening and monitoring efforts. The policy revealed, Surveillance and Reporting: 1. All surveillance findings are collected and reviewed daily by the Infection Preventionist. Further review revealed, Response Driven Testing or Post-Exposure Testing: a) All staff and residents who have had close contact (within 6 feet for a cumulative of 15 minutes over 24 hours), regardless of vaccination status, will be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure.<br><br>During an entrance conference on 03/25/2024 at 10:13 AM, the Administrator and the Director of Nursing (DON) stated that there were five COVID-19 positive residents in the facility.<br><br>During an interview on 03/28/2024 at 10:38 AM, the Infection Preventionist (IP) stated that COVID-19 testing on residents was conducted on 03/21/2024, and the positive results were received by the facility on 03/22/2024. The IP stated that testing of residents was completed on days one, three, and five, and that staff were provided tests and advised to test themselves on days one, three, and five. The IP advised that no staff member had reported a positive test result or symptoms, but he also had no log or documentation of staff testing performed.<br><br>During an interview on 03/28/2024 at 12:09 PM, the IP stated that two new residents had tested positive for COVID-19. The IP stated the COVID-19 tests were completed on 03/26/2024, and results were received on 03/27/2024. The IP stated that he had completed contact tracing.<br><br>During an interview on 03/28/2024 at 12:19 PM with Certified Nurse Aide (CNA) #12 and the IP, CNA #12 stated that she was tested on [DATE] and 03/25/2024 with negative results via a rapid test performed by the IP. The IP stated that he did perform the testing on CNA #12 but failed to document the results.<br><br>A record review of staff COVID-19 test results on 03/29/2024 at 8:21 AM revealed that CNA #11 tested positive for COVID-19 on 03/29/2024.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 03/29/2024 at 8:56 AM, the IP stated that he told the staff to be tested for COVID-19 by the lab yesterday (03/28/2024). He stated that he did the tracing to ensure that all the staff were tested , and CNA #11 was not on the list of people tested . The IP stated that he called CNA #11 and advised him that he needed to be tested before his shift. The IP stated that CNA #11 reported having a runny nose. The IP stated that he was unsure of the last time CNA #11 was tested for COVID-19 prior to receiving a positive test result (on 03/29/2024). The IP indicated that he had created a document to log staff COVID-19 test results moving forward.<br><br>During a phone interview on 03/29/2024 at 10:43 AM, CNA #11 stated that he did not have symptoms of COVID-19 at the time of the positive test result. CNA #11 indicated that he had a runny nose on 03/25/2024 and was advised by the IP to perform a rapid COVID-19 test, but he got sidetracked and didn't complete it. CNA #11 stated that he had tested himself the previous week but failed to report those negative results to the IP. CNA #11 acknowledged that he was required to report test results to the IP if an at-home test was completed by taking a picture and texting the results. CNA #11 stated that the IP again instructed him to perform a rapid test on 03/28/2024, but he got sidetracked and did not complete it until 03/29/2024.<br><br>A review of CNA #11's timesheet revealed that he worked at the facility on 03/25/2024; the next day he worked was on 03/28/2024.<br><br>During an interview on 03/29/2024 at 1:22 PM, the DON stated that when there was direct contact/exposure, the staff should be tested for COVID-19 on days one, three, and five. The DON stated it was the expectation that the type of test performed, and the result were documented for staff testing. The DON stated it was the expectation that staff were identified and tested on days one, three, and five, regardless of whether they were scheduled to work. The DON stated if someone came to work and was exhibiting symptoms without exposure, they tested them. The DON stated staff should not be allowed to work without a COVID-19 test performed if they had symptoms.<br><br>During an interview on 03/29/2024 at 2:13 PM, the Administrator stated that staff should be tested for COVID-19 if they had any symptoms or if they had been exposed. The Administrator stated COVID-19 testing should have been conducted on days one, three, and five. The Administrator stated staff should still test even if they were not working. The Administrator stated if staff acknowledged that they were symptomatic, they should err on the side of caution and test. The Administrator stated it was the expectation that the facility kept documentation of staff testing.<br><br>2. A review of a facility policy titled Perineal Care, revised in February 2018, revealed, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. However, this policy failed to provide steps for how perineal care was to be carried out by the staff performing the task.<br><br>A review of Resident #51's Admission Record revealed the facility admitted the resident on 02/12/2024 with diagnoses that included sepsis, stage 4 pressure ulcer of the sacral region, dementia, and local infection of the skin and subcutaneous tissue.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of Resident #51's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/15/2024, revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Per the MDS, Resident #51 had diagnoses of septicemia, wound infection, and non-Alzheimer's dementia. The MDS revealed that Resident #51 was dependent on staff for toileting hygiene and personal hygiene.<br><br>A review of Resident #51's Care Plan revealed a Focus statement initiated on 02/13/2024 that indicated the resident was at risk for skin breakdown due to incontinence of bowel and bladder. Interventions included to keep skin clean and dry to the extent possible. Further review revealed a Focus statement initiated on 02/12/2024 that indicated the resident had bladder and bowel incontinence. Interventions directed staff to provide adequate skin and peri-care every shift and as needed.<br><br>An observation of Certified Nurse Aide (CNA) #10 performing perineal care on Resident #51 on 03/27/2024 at 9:22 AM revealed that Resident #51 had a bowel movement. CNA #10 used a clean, wet washcloth to clean bowel movement from Resident #51 and discarded that soiled washcloth in the same bag as the clean ones. CNA #10 then grabbed another unused washcloth from the bag, which now contained both unused and soiled washcloths. This washcloth was used to clean bowel movement from Resident #51 and discarded in the bag.<br><br>During an interview on 03/27/2024 at 9:45 AM, CNA #10 stated he tried to keep the washcloths separate in the bag and made sure that the washcloth was not soiled before he used it on Resident #51.<br><br>During an interview on 03/27/2024 at 5:27 PM, the Infection Preventionist (IP) stated that there was no facility policy that detailed the steps of performing perineal care.<br><br>During an interview on 03/28/2024 at 2:05 PM, the IP stated that clean linen and dirty linen were to be kept in separate bags. The IP stated if a soiled towel was placed with a clean towel, all towels were now considered contaminated and should no longer be used.<br><br>During an interview on 03/29/2024 at 1:17 PM, the Director of Nursing (DON) stated that clean and soiled towels could not be placed in the same bag. The DON stated once they were in the same bag, they could no longer use the clean towels as the towels were now contaminated.<br><br>During an interview on 03/29/2024 at 2:05 PM, the Administrator stated that clean should be kept with the clean and dirty with the dirty regarding linen. The Administrator stated they could not use the clean towels after a dirty towel had been placed with them.<br><br>During an interview on 03/29/2024 at 4:15 PM, the Director of Staff Development (DSD) stated that when a staff member was checked off as being competent in a task, it meant that the DSD followed them on the floor, visualized that task performed on the floor, and felt they were competent. DSD indicated that she saw CNA #10 complete peri care while training with another CNA on the floor. The DSD indicated that there was no set procedure for the facility with steps that were being taught to staff. The DSD indicated that she was teaching information to pass state board exams. |