STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055718	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montclair Manor Care Center	5119 Bandera Street Montclair, CA 91763

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35314 Based on interviews, record reviews, and facility document and policy review, the facility failed to have evidence that pharmacy recommendations were communicated to the physician, and physician response was documented for 1 (Resident #11) of 5 sampled residents reviewed for unnecessary medications. Findings included: A review of a facility policy titled Pharmacy Services Overview, revised in April 2019, revealed, 4. The Consultant Pharmacist will provide specific activities related to medication regimen review including: a. a [sic] documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines. b. providing [sic] the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review and to be completed within 14 days. A review of Resident #11's Admission Record indicated the facility admitted the resident on 12/28/2023 with a diagnosis of stage 3 chronic kidney disease. A review of Resident #11's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/22/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #11 received antidepressant and antiplatelet medications during the seven-day lookback period. A review of Resident #11's Order Summary Report with active orders as of 04/17/2024 revealed an order with a start date of 12/28/2023 for hydroxyzine (an antihistamine) oral tablet 10 milligram (mg), with instructions to give 10 mg by mouth every eight hours as needed for itching. Further review revealed there was no stop date. A review of Resident #11's Consultant Pharmacist's Medication Regimen Review dated 02/01/2024 revealed, Currently on Hydroxyzine prn [pro re nata; as needed] itching with strong anticholinergic properties and caution for drowsiness/sedation and risk for fall. Clarify for a stop date, i.e. [id est, that is]: 30 days and or recommend other agents, i.e.: Claritin, Zyrtec, Allegra if clinically Indicated / appropriate. (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #11's Consultant Pharmacist's Medication Regimen Review dated 03/01/2024 revealed, Add a few of the most common side effects on MAR [medication administration record]/monthly recaps, appropriate for Hydroxyzine prn itching. Make sure informed consent is obtained by prescriber. A review of Resident # 11's Progress Notes for the timeframe from 02/01/2024 to 04/17/2024 and the resident's electronic health record revealed no evidence the physician was informed/notified of the pharmacist's recommendations for February and March of 2024. Further review revealed there was no consent completed by the physician for the continued use of the hydroxyzine, and there was no evidence that a stop date had been added to the hydroxyzine order. During an interview on 04/17/2024 at 9:54 AM, the Assistant Director of Nursing (ADON) stated that the pharmacy consultant's recommendations were given to the Director of Nursing (DON), and the DON gave them to the licensed nurses. The ADON stated that once they received the recommendations, they would act in a timely manner, in less than two weeks. The ADON stated the physician's response was documented in the electronic health record under the resident's progress notes. During an interview on 04/17/2024 at 10:18 AM, the DON stated she received the pharmacy recommendations monthly. The DON stated recommendations were emailed to her and that she would print them out. The DON stated there was no designated person, but the licensed nurses helped with the pharmacy recommendations. The DON stated whoever she assigned to help would reach out to the physician and document their response in the resident's progress notes. The DON stated that she reviewed Resident #11's physician's order for hydroxyzine and verified that there was no stop date documented. The DON stated that she reviewed Resident #11's medical record and verified that no informed consent was documented for hydroxyzine. During a follow-up interview on 04/18/2024 at 12:27 PM, the DON stated it was her expectation that pharmacy recommendations were completed and documented in a timely manner. During an interview on 04/18/2024 at 12:59 PM, the Assistant Administrator (AA) stated when there was a pharmacist recommendation, she expected the staff to notify the physician and document the physician's response in the resident's medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 35314 Based on observation, interviews, and record review, the facility failed to ensure single-use packets of topical medications were not stored at the bedside for 1 (Resident #14) of 1 sampled resident observed with medications stored in their room. Findings included: A review of an Admission Record revealed the facility admitted Resident #14 on 09/29/2023 and most recently readmitted the resident on 12/05/2023. A review of a quarterly Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 03/08/2024, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. An observation on 04/16/2024 at 9:48 AM, with Licensed Vocational Nurse (LVN) #3 present, revealed two individual-use packets of topical medications were stored at Resident #14's bedside. One packets was A&D ointment (a skin protectant), and the other packet was hydrocortisone cream (a topical corticosteroid cream). LVN #3 said the medications were not allowed to be kept at the resident's bedside. A review of Resident #14's Order Summary Report, listing active orders as of 04/18/2024, revealed no orders for the use of hydrocortisone cream or A&D ointment. During an interview on 04/16/2024 at 9:55 AM Resident #14 said overnight shift staff left the medications at their bedside. During an interview on 04/16/2024 at 5:03 PM, Certified Nursing Aide (CNA) #4 said she did not know any medication was left at Resident #14's bedside. During an interview on 04/16/2024 at 5:23 PM, LVN #5 said she was the nurse assigned to Resident #14 during the overnight shift. LVN #5 said he did not know a staff member left medications at the resident's bedside and further stated they should have been stored in a medication or treatment cart. During an interview on 04/17/2024 at 10:03 AM, LVN #1 stated Resident #14 did not have an order for the medications observed at the resident's bedside. LVN #1 further stated that she had not removed the medications when she observed them at the bedside in the presence of the surveyor, but she informed another nurse they were there. LVN #1 said the hydrocortisone cream and A&D ointment should be stored in a locked medication or treatment cart.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41493 Based on interviews, record reviews, and facility policy review, the facility failed to ensure documentation was completed and dated accurately for 1 (Resident #12) of 5 sampled residents reviewed for advance directives. Findings included: A review of a facility policy titled Physician Orders for Life Sustaining Treatment (POLST) or Request Regarding Resuscitative Measures Form, with a revision date of [DATE], revealed, 1. Request Regarding Resuscitative Measures: is a written document, signed by an individual with capacity, or a legally recognized health care decision maker, and that [sic] individual's physician, that directs a health care provider regarding resuscitative measures. The policy revealed that this included B. A Physician Orders for Life Sustaining Treatment (POLST) form, as approved by the Emergency Medical Services Authority. Further review revealed, b. A substantially similar printed document is valid and enforceable if all of the following conditions are met: The form is signed by the individual, or the individual's legally recognized health care decision maker, and a physician. A review of a facility policy titled Advance Directive Policy and Procedure, revised in 2017, revealed that it did not address the physician signing and dating the POLST form. A review of Resident #12's Admission Record revealed the facility admitted the resident on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), malignant neoplasm of the prostate, sepsis, chronic respiratory failure with hypoxia, and stage 3 chronic kidney disease. A review of Resident #12's significant change in status Minimum Data Set (MDS), with an Assessment Reference Date of [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed the resident had active diagnoses that included cardiorespiratory conditions, cancer, heart failure, and COPD. A review of Resident #12's care plan revealed a Focus area initiated on [DATE] that indicated the resident had a POLST and to attempt resuscitation/CPR. The care plan revealed interventions that included the medical doctor being made aware of Resident #12's wishes. A review of Resident #12's Order Summary Report with active orders as of [DATE], revealed an order dated [DATE] for code status of Full Code. A review of Resident #12's Physician Orders for Life-Sustaining Treatment (POLST) form with a prepared date of [DATE] revealed the form was neither signed nor dated by the provider. The form revealed under the section titled Cardiopulmonary Resuscitation (CPR) the box for Attempt Resuscitation/CPR was checked. Further review revealed the plastic sleeve that contained the document appeared to have a signature that aligned with the signature line on the POLST form with no date. The POLST form revealed, A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:13 PM, Medical Records (MR) Staff #8 revealed that she and the Social Services/Activities Director were responsible for making sure the physician signed the POLST form. MR Staff #8 acknowledged that the physician had signed the plastic sleeve containing the form and not the actual POLST form. The facility provided an updated POLST form on [DATE] that revealed the provider signature section of the form was signed by Nurse Practitioner (NP) #7 and dated [DATE]. During an interview on [DATE] at 3:53 PM, the Director of Nursing (DON) stated that she was unaware the POLST was not filled out completely. The DON reviewed a copy of the original POLST form and the newly signed POLST form for comparison. The DON indicated that she would need to clarify if the POLST form was filled out while NP #7 was in the building that day. The DON stated that if the form was signed that day, then it should reflect the day it was signed. The DON indicated that facility staff did not backdate any documents. During a phone interview on [DATE] at 9:44 AM, NP #7 stated that she had signed on top of the plastic sleeve. NP #7 stated upon seeing that it was signed on the plastic sleeve, she went back to a date when she thought she had seen Resident #12 and signed the POLST based on that date. NP #7 stated that it was not standard practice to backdate. During an interview on [DATE] at 12:45 PM, the Assistant Administrator stated that facility staff did not backdate and that it was not policy to do that. The Assistant Administrator indicated that everything should have been done in real-time.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 45555 Based on observations, interviews, and facility document review, the facility failed to ensure the required 80 square feet (sq ft) per resident was met for 12 of 18 resident rooms (rooms 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 16 and 18). Findings included: A review of a facility letter dated 07/12/2023 revealed the facility requested a room size waiver for nine rooms in the facility. A review of a facility document titled Client Accommodations Analysis dated 04/17/2024 revealed that rooms 4, 5, 6, 7, 8, 10, 11, 12, 14, 15, 16, and 18 did not provide each resident that resided in the rooms with 80 sq ft per resident. During an interview on 04/18/2024 at 1:14 PM, the Director of Nursing (DON) stated that she knew the facility had a waiver for room sizes. She stated that the size of the rooms did not affect the care that was provided and that she had not received any complaints about the size of the rooms. During an interview on 04/18/2024 at 1:40 AM, the Assistant Administrator (AA) stated that the size of the rooms did not affect resident care. She stated that she had no complaints from residents about the size of the rooms. She stated that the residents had enough room for personal items and were accommodated as much as possible. During an interview on 04/18/2024 at 1:52 PM, the Administrator stated that each resident was supposed to have 80 square feet of room. He stated that the size of the rooms did not affect the care of the residents; they had no complaints about the size of the rooms, and they were able to accommodate the residents' personal belongings.