

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Woods Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 A Street LA Verne, CA 91750	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on observation, interview, and record review, the facility failed to answer the call lights in a timely manner for seven of 16 sampled residents (Residents 2, 15, 30, 31, 148, 149, and 150).</p> <p>This failure resulted in Residents 2, 15, 30, 31, 148, 149, and 150 feel frustrated and had the potential for the residents to experience a decline in psychosocial well-being.</p> <p>Cross reference F725</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR) the AR indicated Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), dysphagia (difficulty swallowing foods or liquids), and hypotension (low blood pressure).</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/28/24, the MDS indicated Resident 2 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 2 was dependent on staff for toileting, dressing, and bathing.</p> <p>During a review of Resident 15's AR the AR indicated Resident 15 was admitted to the facility on [DATE] with multiple diagnoses including hypertension (high blood pressure), history of falling, and legal blindness.</p> <p>During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15 was moderately impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 15 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting, dressing, and bathing.</p> <p>During a review of Resident 30's AR, the AR indicated Resident 30 was admitted to the facility on [DATE] with multiple diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia (a group of thinking and social symptoms that interferes with daily functioning), and history of falls.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 was moderately impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 30 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing. The MDS indicated Resident 30 required supervision or touch assistance from staff for personal hygiene, toileting, and dressing.</p> <p>During a review of Resident 31's AR the AR indicated Resident 31 was admitted to the facility on [DATE] with multiple diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), hypertension (high blood pressure), and history of urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra).</p> <p>During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 was moderately impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 31 required partial/moderate assistance (helper does less than half of the effort) from staff for toileting, dressing, and bathing.</p> <p>During a review of Resident 148's AR the AR indicated Resident 148 was admitted to the facility on [DATE] with multiple diagnoses including history of falling, fracture of the lumbar vertebra (backbone), and hypertension (high blood pressure).</p> <p>During a review of Resident 148's MDS, dated [DATE], the MDS indicated Resident 148 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 148 was dependent on staff for toileting, dressing, showering, and oral hygiene.</p> <p>During a review of Resident 149's AR the AR indicated Resident 149 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), dementia (a group of thinking and social symptoms that interferes with daily functioning), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>During a review of Resident 149's MDS, dated [DATE], the MDS indicated Resident 149 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 149 was dependent on staff for toileting, dressing, showering, and oral hygiene.</p> <p>During a review of Resident 150's AR the AR indicated Resident 150 was admitted to the facility on [DATE] with multiple diagnoses including enterocolitis (an inflammation that occurs throughout your intestines) due to clostridium difficile (C. diff, a bacterium that causes an infection of the colon, the longest part of the large intestine), muscle weakness, and hypertension (high blood pressure).</p> <p>During a review of Resident 150's MDS, dated [DATE], the MDS indicated Resident 150 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 150 required substantial/maximal assistance from staff for toileting, dressing, and bathing.</p> <p>During an interview on 3/26/24 at 9:13 a.m. with Resident 31, Resident 31 stated sometimes the call light took a long time to be answered by the facility staff. Resident 31 stated more than 10 minutes was a long time to get her call light answered from facility staff.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/26/24 at 10:05 a.m. with Resident 149's Resident Representative (RR), Resident 149's RR stated when Resident 149 was first admitted to the facility, Resident 149 had bowel issues and needed assistance from staff to use the bathroom. Resident 149's RR stated Resident 149 would press the call light and it would take staff 15 minutes to respond to the call light. Resident 149's RR stated the RR would have to help Resident 149 to the bathroom because 15 minutes was too long for Resident 149 to wait to use the bathroom. Resident 149's RR stated during Resident 149's firsts week at the facility, the RR had to wash Resident 149's cloths a lot because Resident 149 could not wait for staff to answer Resident 149's call light and would be incontinent (unable to control the excretion of urine or the contents of the bowels) of stool.</p> <p>During an observation on 3/26/24 at 11:48 a.m. in the hallway outside room A, Room A's call light was activated. One staff person was present at the nurses' station.</p> <p>During a concurrent observation and interview on 3/26/24 at 12:00 p.m. with Resident 15 in Room A, Resident 15 stated Resident 15 had called for help with a bedpan. The call light was still activated, staff had not responded yet.</p> <p>During an observation on 3/26/24 at 12:03 p.m. in the hallway outside room A, Certified Nursing Assistant (CNA) 7 entered Room A. Resident 150 waited 15 minutes for staff to respond to call light.</p> <p>During an interview on 3/26/24 at 12:08 p.m. with CNA 7, CNA 7 stated staff try to answer the call lights before it has been a long time. CNA 7 stated a long time would be 15-20 minutes.</p> <p>During an interview on 3/26/24 at 12:20 p.m. with Resident 150, Resident 150 stated Resident 150 had to wait up to one hour to get assistance with changing her soiled briefs.</p> <p>During an interview on 3/26/24 at 1:44 p.m. with Resident 148, Resident 148 stated Resident 148 sometimes waited one to two hours to get assistance from staff. Resident 148 stated Resident 148 had to wait two hours to get changed after wetting her briefs. Resident 148 stated Resident 148 did not feel good waiting that long to get help changing her briefs. Resident 148 stated it was bad for Resident 148's skin to sit in urine for that long. Resident 148 stated the facility was short staffed because when the staff finally help Resident 148, staff told Resident 148 staff were busy helping other residents. Resident 148 stated sometimes staff will respond to Resident 148's call light and tell Resident 148 staff would send another person to help Resident 148. Resident 148 stated Resident 148 would still have to wait a long time for another staff person to finally help Resident 148.</p> <p>During an interview on 3/26/24 at 3:18 p.m. with Resident 2, Resident 2 stated sometimes Resident 2 waited an hour to get help after pressing the call button (call light). Resident 2 stated Resident 2 needed assistance from staff to use the bathroom. Resident 2 stated when staff took too long to answer Resident 2's call light, Resident 2 would have to take himself to the bathroom. Resident 2 stated Resident 2 was frustrated because Resident 2 waited so long for assistance with everything.</p> <p>During an interview on 3/27/2024 at 8:50 a.m. with Resident 30, Resident 30 stated sometimes it took a long time to get help from facility staff. Resident 30 stated facility staff always say, be back in a minute, and you don't see them.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/27/2024 at 2:02 p.m. with CNA 1, CNA 1 stated sometimes CNA 1 did not have enough time to care for the residents assigned to CNA 1. CNA 1 stated when staff call off, the remaining staff at the facility are assigned more residents to care for. CNA 1 stated when that happened, the residents complain more because the residents must wait longer to get changed after soiling briefs.</p> <p>During an interview on 3/29/24 at 10:17 a.m. with the Director of Nursing (DON), the DON stated call lights should be answered within 5 minutes but a maximum of 10 minutes. The DON stated 15 minutes was too long for residents to wait for assistance from facility staff. The DON stated Residents might not be able to control their bladder if they must wait too long for assistance to the bathroom. The DON stated if residents must wait too long in a soiled brief, residents could get a urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra) or experience skin breakdown. The DON stated if the DON was in the same situation, the DON would not feel comfortable. The DON stated residents who must wait too long to get assistance from staff might get irritated or frustrated and might not want to participate in activities. The DON stated it could also negatively affect the residents' dignity.</p> <p>During a review of the facility's policy and procedure (IP&IP) titled, Dignity, revised February 2021, the IP&IP indicated, Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example .promptly responding to a resident's request for tilting assistance .</p> <p>During a review of the facility's IP&IP titled, Call Lights, reviewed 9/9/16, the IP&IP indicated staff should answer the call light promptly. The IP&IP indicated the goal was for staff to answer the call light within 3-5 minutes with the maximum wait time of 10 minutes.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal the need for assistance) was within reach for one of one sampled resident (Resident 28), as indicated in Resident 28's care plans (CP-provides direction on the type of care an individual needs) titled Risk for Falls, The Resident Had Communication Problem and Resident has anxiety manifested by screaming and yelling daily for help with her stuff animals.</p> <p>This failure had the potential to result in Resident 28's needs not met in a timely manner and/or Resident 28 to experience harm if Resident 28 was unable to alert staff during an emergency.</p> <p>Findings:</p> <p>During a review of Resident 28's Admission Record (AR), the AR indicated, Resident 28 was admitted to the facility on [DATE] with diagnoses including muscle weakness (generalized), unspecified glaucoma (a group of eye diseases that can cause vision loss and blindness) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), unspecified.</p> <p>During a review of Resident 28's History and Physical (H&P), dated 6/21/22, the H&P indicated Resident 28 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 28's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/10/24, the MDS indicated Resident 28 had moderate impairment with cognitive skills (the ability to make daily decisions). The MDS indicated Resident 28 required substantial/maximal assistance (helper does more than half the effort) for toileting, bathing, and dressing.</p> <p>During a concurrent observation and interview on 3/26/24 at 10:12 a.m. with Certified Nursing Assistant 3 (CNA 3) in Resident 28's room, Resident 28 was sitting up in a recliner chair next to the window on the right side of Resident 28's bed. Resident 28's call light device was looped around the left side rail of the bed. The call light device was out of reach of Resident 28. CNA 3 stated, Resident 28 could not reach the call light device. CNA 3 unlooped the call light device and was able to place the call light device on the recliner chair's left side arm rest, within Resident 28's reach.</p> <p>During an interview on 3/27/24 at 2:10 p.m. with the MDS Assistant (MDSA), the MDSA stated the call light device was used to call for help and assistance and needed to be placed where the residents could reach (placed usually on the resident's abdomen). The MDSA stated, it was important for the call light device to be within reach of the residents to call for help, for the resident's care and safety.</p> <p>During an interview on 3/29/24 at 9:38 a.m. with CNA 6, CNA 6 stated, it was important for the call light device placed within resident's reach whether the resident was in bed or chair for the resident to contact the staff for help or assistance with resident's needs.</p> <p>During a review of Resident 28's CP titled Risk for Falls, initiated on 7/18/22, the CP indicated to ensure the call light was available to Resident 28 and to answer the call light promptly.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 28's CP titled The Resident Had Communication Problem, initiated on 4/13/23, the CP indicated to provide a safe environment and ensure the call light was within reach.</p> <p>During a review of Resident 28's CP titled Resident has anxiety manifested by screaming and yelling daily for help with her stuff animals, initiated on 5/13/23, the CP indicated to encourage Resident 28 to use the call light for assistance.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Call Light, reviewed 9/9/16, the P&P indicated to respond to resident's requests and needs.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 9) had directions/instructions regarding treatment requests and/or wishes in the event of a medical emergency (any serious illness or condition that poses an immediate risk) as indicated in the facility's Policy and Procedure (P&P) and Resident 9's care plan (CP- provides direction on the type of care an individual needs) titled Resident Request Code status of Full Code (all treatment provided).</p> <p>This failure had the potential for Resident 9 to receive inappropriate or medically unnecessary care, treatment and/or services.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record (AR), the AR indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including subsequent non-ST elevation (NSTEMI) myocardial infarction (heart attack, a medical emergency when heart muscle begins to die due to inadequate blood flow), type 2 diabetes mellitus (high levels of sugar in the blood) and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis).</p> <p>During a review of Resident 9's History and Physical (H&P), dated 12/27/23, the H&P indicated, Resident 9's did not have neurological (functioning of the brain) deficits.</p> <p>During a review of Resident 9's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/28/23, the MDS indicated Resident 9's cognitive (ability to think and reason) status was intact.</p> <p>During a concurrent interview and record review on 3/27/24 at 8:28 a.m. with the facility's Social Services Designee (SSD), Resident 9's undated Physician Orders for Life-Sustaining Treatment (POLST, a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) was reviewed. The POLST indicated, the form was incomplete and there was no signature from Resident 9 nor Resident 9's legally recognized decisionmaker. The SSD stated, Resident 9's POLST was incomplete, and Resident 9 did not have an advance directive (AD, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law [whether statutory or as recognized by the courts of the State], relating to the provision of health care when the individual is incapacitated). The SSD stated, an AD or a completed POLST was important because the AD or POLST indicated the resident's wishes that the resident formulated for their care or appoint a person to make health care decisions in the event the residents were unable to make decisions.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/28/24 at 8:14 a.m. with Registered Nurse (RN), Resident 9's undated POLST form was reviewed. The RN stated, Resident 9's POLST form was not complete. The RN stated, it was extremely important for the POLST form to be completed especially if the resident did not have an AD. The RN stated, it was the admissions nurse and all licensed nurses who were responsible for ensuring the POLST form was completed so the resident's wishes or family's wishes would be honored.</p> <p>During an interview on 3/29/24 at 9:38 a.m. with Resident 9, Resident 9 stated, the facility did not discuss with Resident 9 what Resident 9's treatment requests or wishes in the event Resident 9 had a medical emergency.</p> <p>During a review of Resident 9's CP, titled Resident Request Full Code Status initiated on 10/4/23, the CP indicated to ensure the code status was signed by the resident or responsible party, and in the active medical record.</p> <p>During a review of the facility's P&P titled, Physician Orders for Life Sustaining Treatment (POLST), revised on 3/22/18, the P&P indicated, the POLST would be honored if received on admission and signed by both the resident and a physician in accordance with the guidelines. The P&P indicated, a qualified healthcare provider, preferably a registered nurse or social worker would review the POLST form for completeness (e.g. signed by resident or resident's legally recognized healthcare decision-maker and by a physician).</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview and record review, the facility failed to ensure one of one sampled resident's (Resident 35) Minimum Data Set (MDS, a standardized assessment and care screening tool) was completed accurately.</p> <p>This failure could potentially result in Resident 35 receiving inappropriate care and services based on Resident 35's preferences and goals of care, functional and health status, and strengths and needs.</p> <p>Findings:</p> <p>During a review of Resident 35's Admission Record (AR), the AR indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), unspecified, muscle weakness (generalized) and essential (primary) hypertension (high blood pressure).</p> <p>During a review of Resident 35's History and Physical (H&P) dated 4/28/23, the H&P indicated Resident 35 had the capacity to understand and make decisions.</p> <p>During a review of Resident 35's MDS dated [DATE], the MDS indicated, Resident 35's cognitive (ability to think and process information) skills for daily decision making were intact. The MDS indicated, Resident 35 was receiving oxygen (a colorless, odorless, tasteless gas essential to living organisms) therapy and tracheostomy (a surgically created hole [stoma] in the windpipe [trachea] that provides an alternative airway for breathing) care.</p> <p>During a concurrent observation and interview on 3/26/24 at 10:25 a.m. in Resident 35's room, Resident 35 was asleep in bed on room air and easily arousable. Resident 35 did not have a stoma or scars on her neck. Resident 35 stated, Resident 35 never had a tracheostomy or a breathing tube.</p> <p>During a concurrent interview and record review on 3/27/24 at 1:34 p.m. with the MDS Assistant (MDSA), Resident 35's MDS dated [DATE] was reviewed. The Section O of the MDS indicated, Resident 35 was receiving oxygen therapy and tracheostomy care. The MDSA stated, the MDS was a summary of the resident's condition. The MDSA stated, MDSA did not have a tracheostomy. The MDSA stated, the MDSA did not see a resident admitted to the facility with a tracheostomy.</p> <p>During an interview on 3/27/24 at 1:59 p.m. with the Director of Nursing (DON), the DON stated Resident 35 did not have a tracheostomy.</p> <p>During a concurrent interview and record review on 3/27/24 at 3:45 p.m. with the DON and the MDSA, Resident 35's MDS dated [DATE] was reviewed. The Section O of the MDS indicated Resident 35 was receiving oxygen therapy and tracheostomy care. The DON stated, the MDS was a collection of information about the resident and Resident 35's MDS was incorrect and not accurate. The DON stated Resident 35's MDS should not have been coded with tracheostomy.</p> <p>(continued on next page)</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's undated Policy and Procedure (P&P) titled, Resident MDS Assessment and Care Planning Policy, the P&P indicated the MDS nurse needed to complete the MDS from information gathered.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on interview and record review, the facility failed to ensure resident-centered comprehensive care plans (CP, provides direction on the type of nursing care an individual needs) for three of three sampled residents (Resident 16, 25 and 11) were developed in accordance with the facility's policy and procedure (P&P).</p> <p>a. For Resident 16, the facility failed to develop a CP to address the use of Depakote Sprinkles medication (medication used to treat mental/ mood conditions).</p> <p>b. For Resident 25, the facility failed to individualize the CP related to Resident 25's nutritional weight goals and interventions related to difficulty chewing.</p> <p>c. For Resident 11, the CP related to risk for altered fluid balance did not have measurable objectives and timeframe.</p> <p>This failure had the potential for Residents 16, 25, and 11 to not receive the necessary care and services to achieve their optimal level of functioning.</p> <p>Findings:</p> <p>a. During a review of Resident 16's Admission Record, the AR indicated Resident 16 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (the loss of the ability to think, remember, reason to levels that affect daily life and activities) with agitation, and unspecified psychosis (a severe mental disorder in which a person loses the ability to recognize reality or relate to others).</p> <p>During a review of Resident 16's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/23/2023, the MDS indicated Resident 16 had severely impaired cognition (the ability to make daily decisions). The MDS indicated Resident 16 had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and verbal behaviors (screaming, threatening, or cursing) and physical behaviors (hitting, kicking, pushing, scratching) directed at others.</p> <p>During a review of Resident 16's Order Summary Report (OSR), with active orders as of 3/28/2024, the OSR indicated a physician's order dated 1/16/2024 for Resident 16 to receive Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 milligrams (mg, a unit of weight), one capsule by mouth two times a day for bipolar mania (extremely unstable overjoyed or irritable mood along with an excess activity or energy level) manifested by aggressive outbursts causing harm to self and others.</p> <p>During a concurrent interview and record review on 3/29/2024 at 9:44 a.m. with Licensed Vocational Nurse 2 (LVN 2), Resident 16's CP was reviewed. LVN 2 stated LVN 2 received the order for Depakote Sprinkles and could not find a care plan for the medication, but LVN 2 stated it was required. LVN 2 further stated a care plan was required for the use of Depakote Sprinkles in order to determine if the medication was effective for Resident 16 and to monitor for adverse reactions to Resident 16.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 25's AR, the AR indicated Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type 2 Diabetes (a disease that occurs when blood sugar is too high), dysphagia (swallowing difficulties), and hyperlipidemia (high cholesterol).</p> <p>During a review of Resident 25's MDS dated [DATE], the MDS indicated Resident 25's cognition was intact.</p> <p>During an interview on 3/27/2024 at 9:45 a.m. with Resident 25, Resident 25 stated, Resident 25 recently visited the dentist because of a problem tooth that made it difficult for Resident 25 to chew/eat.</p> <p>During a review of Resident 25's Nutrition/ Dietary Note (DN), dated 3/18/2024, the DN indicated Resident 25 had issues with her teeth making it difficult to eat and Registered Dietician (RD) recommended puree (liquid and cooked food blended to the consistency so little or no chewing is necessary) texture for all meals.</p> <p>During a concurrent interview and record review on 3/28/2024 at 12:51 p.m. with RD, Resident 25's CP dated 2/13/2024 was reviewed. RD stated Resident 25's CP goal indicated to maintain ideal body weight. RD stated, Resident 25's CP did not reflect the plan to maintain the resident's current body weight at 154 pounds (lbs.- unit of weight). RD stated Resident 25's ideal body weight would be near 125 lbs., but RD would not recommend Resident 25 to be too close to the resident's ideal body weight because it would be too low for the resident. RD also stated Resident 25's CP was generalized and not an individualized care plan. RD stated, it was important for the CP to be patient specific because staff needed to know Resident 25's nutrition plan to prevent further weight loss and decline.</p> <p>During an interview on 3/29/2024 at 10:20 a.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated, care plans needed to be tailored to each resident to meet the resident's needs.</p> <p>During an interview on 3/29/2024 at 11:00 a.m. with RD, RD stated when Resident 25's dental issue was identified, it should have been included in Resident 25's plan of care.</p> <p>c. During a review of Resident 11's AR, the AR indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia, gastrostomy (surgical opening into the stomach) and generalized muscle weakness (lack of strength).</p> <p>During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 had severely impaired cognition. The MDS indicated Resident 11 was dependent (helper does all of the effort) for bathing, toileting, and eating.</p> <p>During a concurrent interview and record review on 3/29/2024 at 11:14 a.m. with the Director of Nursing (DON), Resident 11's CP titled, Risk for altered fluid balance, dated 5/18/2022 was reviewed. The CP interventions indicated to evaluate for blood pressure, edema, shortness of breath, and heart rate with a general goal to achieve fluid balance. The DON stated the CP did not have measurable objectives and timeframe. The DON stated the CP needed to be individualized so the residents can maintain their optimal level of functioning.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Careplans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, the comprehensive person-centered care plan: a. includes measurable objectives and timeframes.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 46) received treatment and care in accordance with professional standards of practice by failing to follow physician's order in the administration of Resident 46's antihypertensive medications (medications to treat high blood pressure [BP]).</p> <p>These deficient practices had the potential to result in harmful increase or decrease of Resident 46's blood pressure compromising the resident's health and safety.</p> <p>Findings:</p> <p>During a review of Resident 46's Admission Record (AR), the AR indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including essential (primary) hypertension (high blood pressure) and unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>During a review of Resident 46's History and Physical Examination (H&P), dated 1/26/24, the H&P indicated Resident 46 had multiple past medical history including essential hypertension and multiple current diagnoses including hypertensive heart disease with unspecified congestive heart failure (CHF- condition in which the heart's function as a pump is inadequate to deliver oxygen to the body). The H&P indicated Resident 46 could recognize family, staff and routine half of the time and required frequent prompting.</p> <p>During a review of Resident 46's Minimum Data Set (MDS, an assessment and screening tool), dated 2/1/24, the MDS indicated Resident 46's cognitive (ability to think and process information) status was moderately impaired.</p> <p>During a review of Resident 46's Order Recap Report (ORR) dated 1/25/24 to 2/27/24, the ORR indicated the following:</p> <ul style="list-style-type: none"> - An order on 2/13/24 for Losartan Potassium (medication used to treat high blood pressure) oral tablet 25 milligrams (mg- a measure of weight), 0.5 (half) tablet by mouth one time a day for hypertension (HTN), hold (do not give) if systolic blood pressure (SBP) is less than 120 millimeters of mercury (mmHg- a measurement used to record blood pressure). - An order on 1/25/24 and reordered on 2/20/24 for Metoprolol Tartrate (medication used to treat high blood pressure, chest pain and heart failure) oral tablet 75 mg, one tablet by mouth two times a day for HTN, hold for SBP less than 100 or heart rate (HR) less than 60 beats per minute. - An order on 1/25/24 for Furosemide (medication that helps remove extra fluid from the body and can also help lower blood pressure) oral tablet 80 mg, one tablet by mouth two times a day for CHF. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 3/28/24 at 2:32 p.m. with Licensed Vocational Nurse 1 (LVN 1), Resident 46's Medication Administration Record (MAR) dated February 2024 was reviewed. The MAR indicated, on 2/19/24, Resident 46's BP was 107/69 mmHg and on 2/24/24, Resident 46's BP was 118/67 mmHg. A check mark with LVN 1's initials were documented for the 9:00 am medication administration time on 2/19/24 and 2/24/24. LVN 1 stated, a check mark indicated Losartan was administered/given. LVN 1 stated, the medication should have been held because Resident 46's BP was below the parameter as ordered. LVN 1 stated, the doctor's orders were not followed and giving the medication could have lowered the blood pressure more and affect Resident 46's health status.</p> <p>During a concurrent interview and record review on 3/29/24 at 10:03 a.m. with the Director of Nursing (DON), Resident 46's MAR, dated February 2024 was reviewed. The February 2024 MAR indicated the following:</p> <p>a. On 2/19/24 and 2/24/24 for the 9:00 a.m. administration time with Resident 46's BP of 107/69 mmHg and 118/67 mmHg accordingly and a chart code of a check mark with LVN 1's initials were documented for Losartan.</p> <p>b. On 2/18/24 and 2/25/24 for the 9:00 a.m. administration time with Resident 46's BP of 122/63 mmHg and 126/64 mmHg accordingly and a chart code of 5 with LVN 1's initials were documented for Losartan. The MAR indicated a chart code 5 indicated, Hold/See Progress Notes and a check mark indicated Administered.</p> <p>In a concurrent interview, the DON stated staff needed to check the physician's order and parameters prior to medication administration. The DON stated, a check mark indicated the medication was administered and the code 5 indicated hold medication. The DON stated, the Losartan needed to be held on 2/19/24 and 2/24/24 and should have been given on 2/18/24 and 2/25/24, based on Resident 46's blood pressure readings. The DON stated, if the medication was given incorrectly, it would lower or increase the BP and would adversely affect the resident.</p> <p>c. On 2/5/24 and 2/23/24 for the 9:00 a.m. administration time with Resident 46's BP of 90/69 mmHg and 91/63 mmHg accordingly and a check mark with a staff's initials were documented for Metoprolol.</p> <p>d. On 2/26/24 for the 5:00 p.m. administration time with Resident 46's BP of 99/58 mmHg and a check mark with a staff's initials were documented for Metoprolol. The MAR indicated Furosemide was administered for the 9:00 a.m. and 5:00 p.m. administration times.</p> <p>During a review of the facility's undated Policy and Procedure (P&P) titled, Physician's Orders, the P&P indicated, medication orders must be specified as to how they are to be administered.</p> <p>During a review of the facility's P&P titled, Medication Administration - General Guidelines, revised 2/2020, the P&P indicated medications were administered as prescribed in accordance with good nursing principles and practices and medications were administered in accordance with written orders of the prescriber. The P&P indicated the individual who administered the medication dose records the administration on the resident's MAR directly after the medication was given. The P&P indicated the resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 40) was free of accident (any unexpected or unintentional incident) hazards by failing to maintain Resident 40's bed in a low position. Resident 40 had multiple history of falls (unintentionally coming to rest on the ground, floor, or other lower level).</p> <p>This deficient practice placed Resident 40 at risk for further falls.</p> <p>Findings:</p> <p>During a review of Resident 40's Admission Record (AR), the AR indicated, Resident 40 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (also known as a stroke, refers to damage to tissues in the brain), unspecified abnormalities of gait (how a person walks) and mobility (the ability to move or be moved freely and easily), muscle weakness and dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities).</p> <p>During a review of Resident 40's History and Physical Examination (H&P) dated 10/1/23, the H&P indicated Resident 40 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 40's Fall Risk Evaluation (FRE) dated 9/29/23 timed at 9:15 p.m., the FRE indicated Resident 40 was at risk for falls.</p> <p>During a review of Resident 40's FRE dated 1/1/24 timed at 12 midnight, the FRE indicated Resident 40 was at risk for falls.</p> <p>During a review of Resident 40's SNF/NF to Hospital Transfer Form (TF), dated 1/25/24 timed at 12 midnight, the TF indicated, Resident 40 was transferred to General Acute Care Hospital (GACH) on 1/25/24 at 9:20 a.m. due to unwitnessed fall.</p> <p>During a review of Resident 40's CP titled S/P Pneumothorax (a collapsed lung) from Fall, initiated on 1/26/24, the CP indicated a goal that Resident 40 would not have major injury after a fall. The CP interventions included to keep Resident 40's bed in low position.</p> <p>During a review of Resident 40's FRE dated 1/30/24 timed at 10:40 a.m., the FRE indicated Resident 40 was at risk for falls.</p> <p>During a review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/13/24, the MDS indicated, Resident 40's cognitive (ability to think and process information) skills were severely impaired. The MDS indicated, Resident 40 required substantial/maximal assistance (helper does more than half the effort) to roll left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), to sit to lying (the ability to move from sitting on side of bed to lying flat on the bed) and to sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 40's Order Summary Report (OSR), dated as of 3/29/24, the OSR indicated an order on 2/16/24 for staff to keep Resident 40's bed in low position and keep Resident 40 in areas of high visibility.</p> <p>During a review of Resident 40's Situation, Background, Appearance, Review and Notify (SBAR) dated 2/19/24 timed at 5:15 a.m., the SBAR indicated, Resident 40 had a fall. The SBAR indicated Resident 40 was found sitting on the floor with head toward the nightstand and feet towards the wheelchair.</p> <p>During a review of Resident 40's Post Fall Assessment (PFA), dated 2/19/24 timed at 5:22 p.m., the PFA indicated Resident 40 had a fall on 2/19/24. The PFA indicated Resident 40 was sitting in a wheelchair outside of Resident 40's room, decided to go inside the room and was found sitting on the floor with head towards the nightstand and feet towards wheelchair.</p> <p>During a review of Resident 40's FRE dated 2/19/24 timed at 6:31 p.m., the FRE indicated Resident 40 was at risk for falls.</p> <p>During an observation on 3/27/24 at 7:40 a.m. in Resident 40's room, Resident 40 was in bed with the head of bed up and the bed was not in the lowest position (approximately 3 1/4 feet high) with the breakfast tray on the bedside table that was positioned over Resident 40.</p> <p>During a concurrent observation, interview, and record review on 3/27/24 at 2:10 p.m. with the MDS Assistant (MDSA), Resident 40's CP, titled Actual witnessed fall 1.25.24, was reviewed. The CP indicated the goal was for Resident 40 to be free of falls and one of the interventions was to ensure Resident 40's bed was kept in lowest position. Resident 40 was in bed with eyes closed and easily arousable. Resident 40's bed was not in the lowest position (approximately 3 1/4 feet high). The MDSA asked Resident 40 if the bed could be lowered and Resident 40 stated Yes. The MDSA stated, Resident 40's bed could have been left high after feeding Resident 40. MDSA stated, staff needed to position Resident 40's bed in lowest position to minimize injury or complications in case of a fall.</p> <p>During an interview on 3/29/24 at 9:38 a.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated, Resident 40 was at risk for falls and staff needed to keep Resident 40's bed at the lowest position.</p> <p>During a review of the facility's Policy and Procedure (P&P), titled, Fall Management Program, dated 1/16/14, the P&P indicated, it was the primary goal of the program to use a multidisciplinary approach to falls, to monitor a resident's risk of falling to reduce the frequency and severity of a fall, and to implement measures that would help reduce the fall frequency and injury severity. The P&P indicated, one of the individually specific interventions was maintaining the bed in its lowest position.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on observation, interview and record review, the facility failed to follow the physician's order to check the colostomy site ever shift to make sure it was not leaking and change the leaky colostomy bag in a timely manner for one of one sampled resident (Resident 5), who required colostomy (surgery to create an opening called a stoma. The opening creates a passage from the large intestine to the outside of your body) care and services.</p> <p>These failures had the potential for Resident 5's emotional well-being to be affected and had the potential to develop excoriation/breakdown to the skin surrounding the ostomy (or stoma, an artificial opening in the body, created during an operation such as a colostomy or ileostomy).</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record (AR) the AR indicated Resident 5 was admitted to the facility on [DATE] with multiple diagnoses including myocardial infarction (heart attack, a blockage of blood flow to the heart muscle), colostomy, and hypertension (high blood pressure).</p> <p>During a review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/9/24, the MDS indicated Resident 5 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 5 was dependent on staff for bathing and dressing. The MDS indicated Resident 5 had an ostomy.</p> <p>During an interview on 3/26/24 at 10:24 a.m. with Resident 5, Resident 5 stated Resident 5 had a colostomy. Resident 5 stated Resident 5's colostomy bag was leaking. Resident 5 stated the facility did not have the colostomy supplies necessary to reattach a new colostomy bag over the colostomy stoma. Resident 5 stated there was a plastic bag over the colostomy site to keep stool from leaking onto Resident 5's bed. Resident 5 stated Resident 5 was frustrated because Resident 5 had been bugging facility staff for 3 weeks about ordering the colostomy supplies.</p> <p>During a concurrent observation and interview on 3/26/24 at 3:35 p.m. with Registered Nurse (RN) 1, Resident 5's colostomy site was observed. The ostomy flange (plastic rings used to connect the pouch system to the resident's skin around the stoma) was not secured to Resident 5's skin. Stool was on the edges of the flange. RN 1 stated she was not able to change the colostomy bag because the colostomy supplies were not available. RN 1 stated the supplies were enroute to the facility and should arrive that day. RN 1 confirmed the flange was soiled with stool and the flange was not secured to Resident 5's skin.</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/27/24 at 1:11 p.m. with RN 1, Resident 5's Order Summary Report, dated 3/27/24 was reviewed. Resident 5's Order Summary Report indicated to provide colostomy care every shift. RN 1 stated the physician's order meant staff needed to look at Resident 5's colostomy site every shift and make sure it was not leaking. RN 1 stated if the colostomy site was leaking, staff needed to change the colostomy bag. RN 1 stated the colostomy bag needed to be changed when the outside was soiled or when the flange was peeling away from Resident 5's skin. RN 1 stated RN 1 saw the flange was lifted from Resident 5's skin on 3/25/24. RN 1 stated the Colostomy bag needed to be changed on 3/25/24. RN 1 stated it was important to change the colostomy bag when needed to prevent infection to Resident 5. RN 1 stated residents (in general) who have colostomy may feel self-conscious, so if the bag was leaking, it could cause the residents to have negative feelings.</p> <p>During an interview on 0/27/24 at 1:32 p.m. with the Director of Nursing (DON), the DON stated if residents' (in general) colostomy sites were leaking or soiled, the colostomy bag needed to be changed.</p> <p>During a review of Resident 5's care plan titled, Risk for Impaired skin Integrity d/t Colostomy, dated 5/7/23, the care plan indicated staff were to ensure appropriate wafer stoma size and appropriate adhesive.</p> <p>During a review of Resident 5's care plan titled, (Resident 5) may be at risk for abnormal bowel patterns because of my altered elimination route of a colostomy ., dated 5/12/23, the care plan indicated staff were to provide colostomy care every shift.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Colostomy/Ileostomy Care, revised October 2010, the P&P indicated, The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. The P&P indicated The following equipment and supplies will be necessary when performing this procedure:</p> <ol style="list-style-type: none"> 1. Skin cleansing preparation; 2. Clean drainage bag; 3. Soap and water; 4. Barrier creams and lotions (as indicated); and 5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). 		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 10), received oxygen (O2 [a colorless, odorless, tasteless gas essential for living]) therapy consistent with professional standards of practice and in accordance with the physician's order.</p> <p>This failure resulted in Resident 10 to receive inaccurate oxygen supply and could potentially compromise Resident 10's medical condition.</p> <p>Findings:</p> <p>During a review of Resident 10's Admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and shortness of breath.</p> <p>During a review of Resident 10's Order Summary Report (OSR), the OSR indicated an order on 11/28/22 for continuous O2 at three liters through nasal cannula (NC-tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen).</p> <p>During a review of Resident 10's untitled Care Plan initiated on 1/8/23, the CP indicated for Resident 10 to receive O2 through nasal cannula at three liters (the flow of oxygen received from a delivery device) continuous and humidified.</p> <p>During a review of Resident 10's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 12/25/23, the MDS indicated Resident 10's cognitive (ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated, Resident 10 was receiving O2 therapy.</p> <p>During a review of Resident 10's Medication Administration Record (MAR), dated March 2024, the MAR indicated, Resident 10 to receive continuous O2 at three liters through NC.</p> <p>During a concurrent observation and interview on 3/26/24 at 9:35 a.m. in Resident 10's room, Resident 10 was resting in bed with eyes closed with ongoing oxygen flowing at 4 1/2 liters through NC. Resident 10's Responsible Party (RP) stated, Resident 10 needed to be on 3 liters oxygen.</p> <p>During a concurrent observation and interview on 3/26/24 at 9:42 a.m. with Registered Nurse (RN), Resident 10 was resting in bed with eyes closed with ongoing oxygen flowing at 4 1/2 liters through NC. RN stated, Resident 10 needed to be on 3 liters oxygen as ordered and the licensed nurses needed to check every shift to ensure accurate oxygen flow for Resident 10. RN stated, it was important for Resident 10 to receive oxygen therapy as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised October 2010, the P&P indicated to provide guidelines for safe oxygen administration and preparations included to verify and review the physician's orders or facility protocol for oxygen administration. The P&P further indicated, one of the steps in the procedure was Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staffing resulting in toileting and/or incontinence care were not being provided in a timely manner for seven of 16 sampled residents (Residents 2, 15, 30, 31, 148, 149, and 150).</p> <p>This failure had the potential to result in Residents 2, 15, 30, 31, 148, 149, and 150 to experience skin breakdown and/or placing the residents at risk of experiencing a urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra).</p> <p>(Cross Reference F550)</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR) the AR indicated Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), dysphagia (difficulty swallowing foods or liquids), and hypotension (low blood pressure).</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/28/24, the MDS indicated Resident 2 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 2 was dependent on staff for toileting, dressing, and bathing.</p> <p>During a review of Resident 15's AR the AR indicated Resident 15 was admitted to the facility on [DATE] with multiple diagnoses including hypertension (high blood pressure), history of falling, and legal blindness.</p> <p>During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15 was moderately impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 15 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting, dressing, and bathing.</p> <p>During a review of Resident 30's AR, the AR indicated Resident 30 was admitted to the facility on [DATE] with multiple diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) , dementia (a group of thinking and social symptoms that interferes with daily functioning), and history of falls.</p> <p>During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 was moderately impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 30 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing. The MDS indicated Resident 30 required supervision or touch assistance from staff for personal hygiene, toileting, and dressing.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 31's AR the AR indicated Resident 31 was admitted to the facility on [DATE] with multiple diagnoses including congestive heart failure (CHF, the heart doesn't pump blood as well as it should), hypertension (high blood pressure), and history of urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra).</p> <p>During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 was moderately impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 31 required partial/moderate assistance (helper does less than half of the effort) from staff for toileting, dressing, and bathing.</p> <p>During a review of Resident 148's AR the AR indicated Resident 148 was admitted to the facility on [DATE] with multiple diagnoses including history of falling, fracture of the lumbar vertebra (backbone), and hypertension (high blood pressure).</p> <p>During a review of Resident 148's MDS, dated [DATE], the MDS indicated Resident 148 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 148 was dependent on staff for toileting, dressing, showering, and oral hygiene.</p> <p>During a review of Resident 149's AR the AR indicated Resident 149 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), dementia (a group of thinking and social symptoms that interferes with daily functioning), and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>During a review of Resident 149's MDS, dated [DATE], the MDS indicated Resident 149 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 149 was dependent on staff for toileting, dressing, showering, and oral hygiene.</p> <p>During a review of Resident 150's AR the AR indicated Resident 150 was admitted to the facility on [DATE] with multiple diagnoses including enterocolitis (an inflammation that occurs throughout your intestines) due to clostridium difficile (C. diff, a bacterium that causes an infection of the colon, the longest part of the large intestine), muscle weakness, and hypertension (high blood pressure).</p> <p>During a review of Resident 150's MDS, dated [DATE], the MDS indicated Resident 150 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 150 required substantial/maximal assistance from staff for toileting, dressing, and bathing.</p> <p>During an interview on 3/26/24 at 9:13 a.m. with Resident 31, Resident 31 stated sometimes the call light took a long time to be answered by the facility staff. Resident 31 stated more than 10 minutes was a long time to get her call light answered from facility staff.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/26/24 at 10:05 a.m. with Resident 149's Resident Representative (RR), Resident 149's RR stated when Resident 149 was first admitted to the facility, Resident 149 had bowel issues and needed assistance from staff to use the bathroom. Resident 149's RR stated Resident 149 would press the call light and it would take staff 15 minutes to respond to the call light. Resident 149's RR stated the RR would have to help Resident 149 to the bathroom because 15 minutes was too long for Resident 149 to wait to use the bathroom. Resident 149's RR stated during Resident 149's firsts week at the facility, the RR had to wash Resident 149's cloths a lot because Resident 149 could not wait for staff to answer Resident 149's call light and would be incontinent (unable to control the excretion of urine or the contents of the bowels) of stool.</p> <p>During an observation on 3/26/24 at 11:48 a.m. in the hallway outside room A, Room A's call light was activated. One staff person was present at the nurses' station.</p> <p>During a concurrent observation and interview on 3/26/24 at 12:00 p.m. with Resident 15 in Room A, Resident 15 stated Resident 15 had called for help with a bedpan. The call light was still activated, staff had not responded yet.</p> <p>During an observation on 3/26/24 at 12:03 p.m. in the hallway outside room A, Certified Nursing Assistant (CNA) 7 entered Room A. Resident 15 waited 15 minutes for staff to respond to call light.</p> <p>During an interview on 3/26/24 at 12:08 p.m. with CNA 7, CNA 7 stated staff try to answer the call lights before it has been a long time. CNA 7 stated a long time would be 15-20 minutes.</p> <p>During an interview on 3/26/24 at 12:20 p.m. with Resident 150, Resident 150 stated Resident 150 had to wait up to one hour to get assistance with changing her soiled briefs. Resident 150 stated Resident 150 was admitted to the facility with C. diff following a surgery to reverse her colostomy (surgery to create an opening called a stoma. The opening creates a passage from the large intestine to the outside of your body). Resident 150 stated Resident 150's buttock felt sore and irritated because she was left in her soiled briefs for too long.</p> <p>During an interview on 3/26/24 at 1:44 p.m. with Resident 148, Resident 148 stated Resident 148 sometimes waited one to two hours to get assistance from staff. Resident 148 stated Resident 148 had to wait two hours to get changed after wetting her briefs (diaper). Resident 148 stated Resident 148 did not feel good waiting that long to get help changing her briefs. Resident 148 stated it was bad for Resident 148's skin to sit in urine for that long. Resident 148 stated the facility was short staffed because when the staff finally help Resident 148, staff told Resident 148 staff were busy helping other residents. Resident 148 stated sometimes staff will respond to Resident 148's call light and tell Resident 148 staff would send another person to help Resident 148. Resident 148 stated Resident 148 would still have to wait a long time for another staff person to finally help Resident 148.</p> <p>During an interview on 3/26/24 at 3:18 p.m. with Resident 2, Resident 2 stated the facility did not have enough staff. Resident 2 stated sometimes Resident 2 waited an hour to get help after pressing the call button (call light). Resident 2 stated Resident 2 needed assistance from staff to use the bathroom. Resident 2 stated when staff took too long to answer Resident 2's call light, Resident 2 would have to take himself to the bathroom. Resident 2 stated Resident 2 was not supposed to go to the bathroom unassisted by staff because Resident 2 might fall. Resident 2 stated Resident 2 was frustrated because Resident 2 waited so long for assistance with everything.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/27/2024 at 8:50 a.m. with Resident 30, Resident 30 stated sometimes it took a long time to get help from facility staff. Resident 30 stated facility staff always say, be back in a minute, and you don't see them.</p> <p>During an interview on 3/27/2024 at 2:02 p.m. with CNA 1, CNA 1 stated sometimes the facility is short staffed because staff call off. CNA 1 stated sometimes CNA 1 did not have enough time to care for the residents assigned to CNA 1. CNA 1 stated when staff call off, the remaining staff at the facility are assigned more residents to care for. CNA 1 stated when that happened, the residents complain more because the residents must wait longer to get changed after soiling diapers.</p> <p>During an interview on 3/28/24 at 8:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the facility had a staffing shortage. LVN 1 stated sometimes the staffing shortage made her feel like crying. LVN 1 stated the facility had a lot of call offs from the scheduled CNAs and Licensed staff. LVN 1 stated the facility hires new staff but that the new staff do not stay.</p> <p>During an interview on 3/28/24 at 4:19 p.m. with CNA 2, CNA 2 stated CNA 2 worked the 3-11 shift, CNA 2 stated there were some days when CNA 2 was not able to get to all the residents in a timely manner. CNA 2 stated Residents will get upset when their call lights are not answered quick enough. CNA 2 stated on days CNA is assigned to care for 10 - 11 residents, CNA 2 cannot get to call lights fast enough.</p> <p>During an interview on 3/29/24 at 10:17 a.m. with the Director of Nursing (DON), the DON stated call lights should be answered within 5 minutes but a maximum of 10 minutes. The DON stated 15 minutes was too long for residents to wait for assistance from facility staff. The DON stated Residents might not be able to control their bladder if they must wait too long for assistance to the bathroom. The DON stated if residents must wait too long in a soiled brief, residents could get a urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra) or experience skin breakdown. The DON stated if the DON was in the same situation, the DON would not feel comfortable. The DON stated residents who must wait too long to get assistance from staff might get irritated or frustrated and might not want to participate in activities. The DON stated it could also negatively affect the residents' dignity.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Call Lights, reviewed 9/9/16, the P&P indicated staff should answer the call light promptly. The P&P indicated the goal was for staff to answer the call light within 3-5 minutes with the maximum wait time of 10 minutes.</p> <p>During a review of the facility's P&P titled, Staffing, revised October 2017, the P&P indicated, Our facility provides sufficient numbers of staff . in accordance with resident care plans and the facility assessment. The P&P indicated Staffing numbers . of direct care staff are determined by the needs of the residents .</p> <p>During a review of the facility's facility assessment, titled, Facility Assessment Tool, dated 3/15/24, the facility assessment indicated the resident population at the facility required bowel/bladder services which included responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents was free from unnecessary psychotropic (medicines that alter chemical levels in the brain which impact mood and behavior) medication (Resident 30). Resident 30's order for Lorazepam (medication to treat anxiety [an unpleasant state of inner turmoil and fear]) did not have an end date within 14 days from the time it was ordered.</p> <p>This failure had the potential for Resident 30 to receive unnecessary psychotropic medication that could result in adverse consequences for the resident.</p> <p>Findings:</p> <p>During a review of Resident 30's Admission Record (AR), the AR indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia (the loss of the ability to think, remember, reason to levels that affect daily life and activities), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).</p> <p>During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/15/2024 the MDS indicated Resident 30 had mildly impaired cognition (the ability to make daily decisions).</p> <p>During a review of Resident 30's Order Summary Report (OSR), with active orders as of 3/28/2024, the OSR indicated a physician's order dated 1/20/2024 for Resident 30 to receive Lorazepam 0.5 milligrams (mg, unit of weight), one tablet by mouth every four hours as needed for anxiety manifested by restlessness.</p> <p>During a concurrent interview and record review on 3/28/2024 at 10:09 a.m. with Social Services Director (SSD), the Consultant Pharmacist's Note to Attending Physician/ Prescriber (NTAP), dated 2/11/2024, was reviewed. The NTAP indicated, Per F758, as needed anxiolytics and hypnotics must be limited to 14 days. Please discontinue as needed Lorazepam so that the facility is compliant with regulations. The SSD stated the hospice (supportive care to people in the final phase of a terminal illness) physician did not discontinue the order because Resident 30's family wanted to keep the medication for the resident.</p> <p>During a review of Resident 30's Medication Administration Record (MAR) dated 3/1/2024 - 3/31/2024, the MAR indicated Lorazepam was not administered during this period.</p> <p>During an interview on 3/28/2024 at 4:06 p.m. with the Director of Nursing (DON), the DON stated if the facility did not follow pharmacy recommendations, the resident would not get re-evaluated for unnecessary medications.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Medication Monitoring and Management, dated 10/2012, the P&P indicated, If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication is documented in the resident's active record.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42307</p> <p>Based on observation, interview and record review, the facility failed to follow safe and proper food storage and preparation practices in one of one facility kitchen, in accordance with professional standards for food service safety and the facility's policies and procedures (P&P) by failing to ensure:</p> <p>a. Food items were labeled/dated in the kitchen.</p> <p>b. Cold foods were held at 41 degrees Fahrenheit (F, a unit of measurement used to measure temperature) or lower.</p> <p>These failures had the potential for food borne illness (illness caused by the ingestion of contaminated food or beverage) and/or affect the quality and palatability of food for the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 3/26/24 at 8:16 a.m. with Utility Worker (UW) 1, in the initial tour of the kitchen, the following were observed:</p> <ol style="list-style-type: none"> One unlabeled/undated used 18 oz (ounces, a unit of weight) jar of peanut butter on the food preparation counter. One tray of 18 unlabeled/undated individual servings of chocolate pudding covered in plastic, inside the Walk-in Refrigerator. One tray of five unlabeled/undated individual containers of cut up fresh fruits covered in plastic, inside the Walk-in Refrigerator. One unlabeled/undated plastic bag of dinner rolls on top of the shelf next to the Walk-in Refrigerator. One unlabeled/undated plastic bin of yellow onions and one unlabeled/undated plastic bin of red onions stored on a rack in the food preparation area by the stove. <p>UW 1 stated, the food items needed to be labeled once opened as the practice of the facility was to label right away when food items were opened. UW 1 stated, it was important to label/date opened food items so that staff will know how long the food items will be used for, so not to serve food items that went bad that could get the residents sick.</p> <p>During a concurrent observation and interview on 3/29/24 at 11:40 a.m. with the Executive Chef (EC) during the follow-up visit to the kitchen, the EC stated, the kitchen had a labeling machine that showed expiration date and date food item was purchased. The EC stated, it was important to label/date food items to keep track, to ensure the facility was providing fresh food to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 3/29/24 at 11:55 a.m. with the EC, during the trayline (a system of food preparation in which trays move along an assembly line) in the kitchen, one bowl of macaroni salad covered in plastic wrap inside the Reach-in Refrigerator had a temperature of 44 degrees F. A tray of multiple bowls of macaroni salad individually covered in plastic wrap on the mobile pan rack had a temperature of 45 degrees F. The EC stated macaroni salad was considered cold food and the temperature needed to be 41 degrees or below. The EC stated, the macaroni salad needed to be placed on ice to keep the recommended food temperature.</p> <p>During an interview on 3/29/24 at 12:28 p.m. with UW 1, UW 1 stated, kitchen staff had the responsibility of checking the cold food items. UW 1 stated, it was important for food to have the proper temperature to ensure the food was fresh, tasted good and safe to be served to the residents.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Food and Supply Storage, revised 1/23, the P&P indicated, all food, nonfood items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P indicated, to cover, label and date unused portions and open packages. The P&P indicated, to date and rotate items; first in, first out (FIFO). The P&P indicated to label both the bin and the lid for dry storage. The P&P indicated, as with all refrigerated storage, temperature must be maintained at 41 degrees Fahrenheit or below.</p> <p>During a review of the facility's P&P titled, Refrigerated Storage Life of Foods, dated January 2023, the P&P indicated, to label when product was opened.</p> <p>During a review of the facility's Temperature Log and Checklist (TLC), dated 3/3/24 and 3/2/24, the TLC did not indicate food items with corresponding temperatures. The TLC indicated, a minimum holding standard temperature for cold food and beverage was equal or less than 41 degrees. The TLC indicated, for cold items be placed in refrigeration or on ice.</p> <p>During a review of the facility's TLC, dated 3/29/24, the TLC indicated, cold items in ice. The TLC did not indicate cold items or temperatures.</p> <p>During a review of the facility's menu titled, Dining Services Menu, dated 3/24/24 to 3/30/24, the menu indicated, macaroni salad was on the lunch menu for 3/29/24.</p>		

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NAME OF PROVIDER OR SUPPLIER Woods Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 A Street LA Verne, CA 91750	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview and record review, the facility failed to follow standard infection control practices in accordance with the facility's Policies and Procedures (P&P) by failing to:</p> <p>a. Safely and hygienically store personal toiletries and belongings for two of two sampled residents (Residents 9 and 98)</p> <p>b. Establish a surveillance plan to monitor or track infections in the facility in accordance with the facility's policy and procedure titled Infection Prevention and Control Program.</p> <p>These failures had the potential to result in cross contamination and/or spread of infection to the residents and staff.</p> <p>Findings:</p> <p>a.1. During a review of Resident 9's Admission Record (AR), the AR indicated Resident 9 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including myocardial infarction (heart attack, a medical emergency when the heart muscle begins to die because it isn't getting enough blood flow), type 2 diabetes mellitus (high levels of sugar in the blood) and end stage renal disease (ESRD - a medical condition in which a person's kidneys cease functioning on a permanent basis).</p> <p>During a review of Resident 9's Inventory of Personal Effects (IPE), dated 11/10/23, the IPE did not indicate Resident 9 had an electric toothbrush.</p> <p>During a review of Resident 9's History and Physical (H&P), dated 12/27/23, the H&P indicated Resident 9's did not have neurological (functioning of the brain) deficits.</p> <p>During a review of Resident 9's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/28/23, the MDS indicated Resident 9's cognitive (ability to think and reason) status was intact. The MDS indicated Resident 9 required setup or clean-up assistance (helper sets up or cleans up) with oral hygiene and dependent (helper does all of the effort) for toileting hygiene and shower/bathe.</p> <p>a.2. During a review of Resident 98's AR, the AR indicated Resident 98 was admitted on [DATE] with diagnoses including heart failure, unspecified, type 2 diabetes mellitus without complications and unspecified psychosis (a severe mental disorder characterized by a disconnection from reality).</p> <p>During a review of Resident 98's IPE dated 3/21/23, the IPE did not indicate Resident 98 had an electric toothbrush.</p> <p>During a review of Resident 98's History and Physical (H&P), dated 3/21/24, the H&P indicated Resident 98 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a concurrent observation and interview on 3/26/24 at 9:25 a.m. with Certified Nursing Assistant 5 (CNA 5) inside Resident 9 and Resident 98's shared restroom, an unlabeled mauve colored wash basin and an unlabeled gray colored wash basin were stored on top of one another, tucked behind the toilet pipe. An unlabeled mauve colored emesis basin with 2 unlabeled tubes of used toothpaste and 2 unlabeled bottles of used mouthwash rinse was stored in the shared restroom's niche. An unlabeled electric personal toothbrush was observed on the sink. CNA 5 stated, the wash basins should not have been stored behind the toilet pipe and should have been labeled, placed inside a plastic bag, and stored separately in Resident 10 and Resident 98's bedside drawers for infection control. CNA 5 stated, CNA 5 thought the personal electric toothbrush belonged to Resident 9. CNA 5 stated, the resident's toiletries needed to be labeled because the toiletries were personal items and for staff to know who it (personal items) belonged to, for infection control.</p> <p>During an interview on 3/27/24 at 12:21 p.m. with the Infection Preventionist (IP), the IP stated, resident's personal belongings including emesis basin, toiletries such as toothpaste and electric toothbrush needed to be labeled with resident's name and bed number. The IP stated, it was important to label personal belongings and toiletries to avoid confusion and taking the wrong item that could lead to cross contamination, for infection control.</p> <p>During a review of the facility's P&P titled, Infection Prevention and Control Program, revised October 2018, the P&P indicated, an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P indicated, one of the important facets of infection prevention included instituting measures to avoid complications or dissemination and ensuring staff adhere to proper techniques and procedures.</p> <p>During a review of the facility's P&P titled, Bedpan/Urinal, Offering/Removing, revised February 2018, the P&P indicated, to clean wash basin and return to designated storage area.</p> <p>44027</p> <p>48729</p> <p>b. During an interview on 3/28/24 at 11:23 a.m. with the Director of Nursing (DON), the DON stated the facility did not track or monitor infections other than COVID-19 (a highly contagious respiratory disease caused by the SARS-CoV-2 virus). The DON stated when a resident had a communicable disease, the facility will call the public health nurse for advice on how to handle the situation. The DON stated most of the infections among residents were from hospital admissions. The DON further stated that if the facility does not track or monitor for infectious diseases, there was a potential for a spread of infection.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, revised 10/2022, the P&P indicated the IP maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>48729</p> <p>Based on interview and record review, the facility failed to ensure one of one facility's Infection Preventionist (IP- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment) completed a specialized training in infection prevention and control as indicated in the facility's job description of the Infection Preventionist.</p> <p>This failure had the potential for lack of oversight of the facility's infection control practices by the IP.</p> <p>Findings:</p> <p>During an interview on 3/28/2024 at 11:23 a.m. with the IP, IP stated IP has not completed the modules required for IP certification and was currently on module five of 24.</p> <p>During an interview on 3/28/2024 at 11:23 a.m. with the Director of Nursing (DON), the DON stated IP was still in training and DON was helping to complete IP duties while IP was completing the modules for certification. When asked if the facility currently had a certified IP, the DON stated, No, there's nothing official.</p> <p>During a review of the facility's job description for IP titled, Supervisor Position Description (SPD), dated 11/2023, the SPD indicated under specific position duties, the IP provides oversight and evaluation of the infection control program as the facility's Infection Preventionist. The SPD indicated under qualifications, the IP needed to complete specialized training in infection prevention and control.</p>		