

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Osage Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 South Osage Ave Inglewood, CA 90301	

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 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** 46144</p> <p>Based on observation, interview, and record review the facility failed to ensure one out of three sampled residents, (Resident 26) call light was within reach.</p> <p>This deficient practice placed Resident 26 at risk for accidents and had the potential to delay in meeting Resident 26 physical and emotional needs.</p> <p>Findings:</p> <p>During an observation on 10/30/2024 at 10:29 a.m. Resident 26's call light was hanging on the side of the bed and not within reach.</p> <p>During a review of Resident 26's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (a chronic metabolic disease that causes high blood glucose levels), and gastro-esophageal reflux disease ([GERD] is a condition in which the stomach contents leak backward from the stomach into the esophagus).</p> <p>During a review of Resident 26's History and Physical (H&P), dated 7/7/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions.</p> <p>During a review of Resident 26's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/28/2024 the MDS indicated, Resident 26's cognition (ability to learn, reason, remember, understand, and make decisions) was resident usually understands. The MDS indicated Resident 26 was dependent on staff for toileting hygiene, showering, and dressing.</p> <p>During a review of Resident 26's care plan dated 9/4/2024, titled, The Resident is at risk for falls related to gait/balance problems, the care plan indicated Resident 26 will be free from falls. The staff intervention was to ensure the Resident 26 call light was always within reach and encouraged Resident 26 to use it for assistance when needed.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/30/2024 at 11:45 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 26's room, Resident 26 call light was hanging on the bedrail not within reach. CNA 3 stated, Resident 26's call light was not within reach. CNA 3 stated if the resident needed to call for help, she would not be able to reach for the call light. CNA 3 stated it was important to have the call light within reach because the resident may be having an emergency such as choking, and she would not be able to call for help.</p> <p>During an interview on 10/31/2024 at 11:51 a.m. with Director of Staff Development (DSD), the DSD stated it was important for the staff to place the call light within reach for Resident 26. The DSD stated the call light is the communication tool used to let the staff know when residents need assistance. The DSD stated if the call light is not within reach, Resident 26 could not call if she needed something or was under distress (a state of pain or suffering that can be physical emotional or social). The DSD stated the requirement is to have the call light within reach.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 1/2012, the P&P indicated, the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. The P&P indicated call cords will be placed within reach in the resident's room.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Certified Nursing Assistant Job Description, date unknown, the P&P indicated a nursing assistant responsible for providing routine nursing care in accordance with established policies and procedures. The P&P indicated to assure the call system is attached to the bed and within easy reach at all times for residents.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</p> <p>Based on interview and record review, the facility failed to:</p> <p>1. Inform the physician one of one sampled resident (Resident 38) refused to take trazodone (medication to treat depression).</p> <p>This deficient practice placed Resident 38 at risk for worsening of depression and withdrawal effect that could cause medical complications.</p> <p>Findings:</p> <p>During a review of Resident 38's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 38 was admitted to the facility on [DATE]. Resident 38's admission diagnoses included major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest), Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness.</p> <p>During a review of Resident 38's History and Physical (H&P), dated 4/10/2024, the H&P indicated, Resident 38 had the capacity to understand and make decisions.</p> <p>During a review of Resident 38's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 9/20/2024, the MDS indicated, Resident 38's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 38 required substantial assistance (helper does more than half the effort) from staff with upper body dressing and personal hygiene.</p> <p>During a review of Resident 38's Order Summary Report (a document containing active orders) dated 10/31/2024, indicated Resident 38 had a physician's order of trazodone 25 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime every Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday (6 days a week) for major depression manifested by inability to sleep.</p> <p>(continued on next page)</p>

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<p>F 0580</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 10/31/2024 at 10:52 a.m., with the Director of Nursing (DON), Resident 38's Medication Administration Records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for October 2024 was reviewed. The DON stated Resident 38 refused to take the trazadone 25mg on 10/2/2024, 10/3/2024, 10/4/2024, 10/5/2024, 10/8/2024, 10/9/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/14/2024, 10/15/2024, 10/16/2024, 10/17/2024, 10/21/2024, 10/22/2024, 10/23/2024, 10/26/2024, 10/28/2024, and 10/29/2024 (19 days). The DON stated the facility process for the refusal of medication was to inform the physician and chart the refusal on the progress notes documenting three attempts to offer the medication. The DON stated a change of condition documentation should be completed by the licensed nurse. The DON stated there was no documentation indicating Resident 38's physician was notified of Resident 38's persistent and continued refusal to take trazadone. The DON further stated it was important to notify the physician of Resident 38's continued refusal to take trazadone for him to offer different medication and to evaluate what was the reason for his refusal.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Refusal of Treatment, dated 1/1/2012, the P&P indicated, The Charge Nurse of DNS will document information relating to the refusal in the resident's medical record and the documentation will include the date and time the attending physician was notified and his or her response.</p> <p>During a review of the facility's P&P titled, Medication Administration, dated 1/1/2012, the P&P indicated, The licensed nurse will attempt to give the medications several times, but if resident continues to refuse after one hour, the refused medication will be destroyed and licensed nurse will notify MD and document in the medical record.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</p> <p>Based on interview and record review, the facility failed to:</p> <p>1.Ensure an accurate Minimum Data Set ([MDS] - a federally mandated resident assessment tool), was completed accurately for one of 13 sampled residents (Resident 9).</p> <p>This deficient practice resulted in incorrect data transmitted to Center for Medicare and Medicaid Services (CMS) and had the potential for a poor care planning which could affect the health and safety of Resident 9.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), muscle weakness congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>During a review of Resident 9's History and Physical (H&P), dated 12/11/2023, the H&P indicated, Resident 9 had the capacity to understand and make decisions.</p> <p>During a review of Resident 9's MDS annual assessment, dated 9/25/2024, the MDS indicated Resident 9's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 9 required maximum assistance (helper does more than half the effort) from staff with toileting hygiene and upper and body dressing.</p> <p>During a review of Resident 9's Order Summary Report (a document containing active orders), dated 10/1/2024, the Order Summary Report indicated, Resident 9 had a physician's order of dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) every Tuesday, Thursday, and Saturday.</p> <p>During a concurrent interview and record review on 10/30/2024 at 4:01 p.m., with the Minimum Data Set Nurse (MDS Nurse), Resident 9's MDS annual assessment dated [DATE] was reviewed. The MDS Nurse stated the MDS annual assessment of Resident 9 was completed inaccurately. The MDS Nurse stated there was a wrong entry on the MDS section O (Special Treatments, Procedures, and Programs) J1 (dialysis). The MDS Nurse stated there should be a checked mark on Section O (J1) since Resident 9 was receiving dialysis treatment every Tuesday, Thursday, and Saturday. The MDS Nurse stated MDS assessment reflects the condition of the resident and the facility's plan of care based on their diagnoses, treatment, and care needs. The MDS Nurse stated it was a mandated requirement to submit and encode MDS assessment completely and accurately because it could affect the delivery of care and services to the residents.</p> <p>(continued on next page)</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, RAI Process, dated 10/4/2016, the P&P indicated, To provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission. The P&P also indicated the facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS RAI MDS 3.0 Manual.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 46144</p> <p>Based on interview and record review the facility failed to ensure one out of three sampled residents, (Resident 26) had a care plan to:</p> <ol style="list-style-type: none"> 1. Monitor the frequency of outside food being brought in by family. 2. Monitor Resident 26's ability to tolerate regular textured (consists of normal, everyday foods textures that including hard, chewy, dry, and crunch foods) food brought in by family. <p>These deficient practices resulted in failure to monitor Resident 26's prescribed pureed textured diet (a texture-modified diet that consists of foods that are ground, pressed, or strained until they have a smooth, soft consistency, like pudding) and had the potential to place Resident 26 at risk for choking.</p> <p>Findings:</p> <p>During an observation on 10/29/2024 at 10:15 a.m. in Resident 26's room, there was an empty box of a burger, large bag of potato chips, crackers, and cans of soda on the bedside table.</p> <p>During a review of Resident 26's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated Resident 26's diagnoses included chronic obstructive pulmonary (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (a chronic metabolic disease that causes high blood glucose levels), and gastro-esophageal reflux disease ([GERD] is a condition in which the stomach contents leak backward from the stomach into the esophagus).</p> <p>During a review of Resident 26's History and Physical (H&P), dated 7/7/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions.</p> <p>During a review of Resident 26's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/28/2024 the MDS indicated, Resident 26's cognition (ability to learn, reason, remember, understand, and make decisions) usually able to understand. The MDS indicated Resident 26 required oxygen therapy (a treatment that provided extra oxygen to people with breathing problems). The MDS indicated Resident 26 was dependent on staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 26 required a mechanical altered diet such as textured food that is pureed (a meal plan that consist of foods and drinks to make it easier to chew and swallow).</p> <p>During a review of Resident 26's physician orders, titled, Order Summary Report, dated 7/11/2024, the Order Summary Report indicated, Resident 26 was to have a pureed texture diet.</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 - Few</p>	<p>During an interview on 10/29/2024 at 10:20 a.m. with Resident 26, Resident 26 stated she had a hamburger yesterday and her family brings her food when they visit. Resident 26 stated, certain types of food her family brings, makes her cough when she eats her food. Resident 26 stated the staff does not come into the room after she eats food brought in by her family to check if she was able to tolerate the food.</p> <p>During an interview on 10/31/2024 at 12:55 p.m. with the Director of Nursing (DON), the DON stated there was no documentation of what texture or type of foods the family brought to Resident 26. The DON stated there was no care plan on how often the resident should be monitored while eating food not prescribed by the physician. The DON stated the staff needs to know when the family is bringing in regular food texture. The DON stated if we don't know when the family is bringing the regular textured food; the resident could have issues such as choking, coughing, and aspiration (inhaling food, liquid, or other material into the lungs).</p> <p>During an interview on 11/1/2024 at 4:18 p.m. with the Registered Dietitian (RD), the RD stated, I was not aware Resident 26 was receiving food from family that was not prescribed. The RD stated Resident 26 should be monitored for the types of food and textures being brought in by the family. The RD stated a care plan should have been developed to monitor when the family brought in food into the facility. The RD stated Resident 26 needed to be monitored during mealtimes, to prevent choking.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated the baseline care plan must include information necessary to properly care for each resident with safety concerns to prevent decline or injury and would identify needs for supervision.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on record review and interview the facility failed to:</p> <p>1. Revise one of three sampled residents (Resident 26) interventions identified by the multidisciplinary care team ([IDT] group of healthcare professionals from different disciplines) who was at risk of aspirating (inhalation of food or liquid into the lungs).</p> <p>The deficient practice had the potential for repeat occurrence.</p> <p>Findings:</p> <p>During a review of Resident 26's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 26's diagnoses included chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing), diabetes mellitus ([DM] a chronic metabolic disease that causes high blood glucose levels), and gastro-esophageal reflux disease ([GERD] a condition in which the stomach contents leak backward from the stomach into the esophagus).</p> <p>During a review of Resident 26's History and Physical (H&P) dated 7/7/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions.</p> <p>During a review of Resident 26's Order Summary Report, dated 7/11/2024, the Order Summary Report indicated, to provide Resident 26 with a pureed textured diet (food that are ground and pressed to have a smooth consistency).</p> <p>During a review of Resident 26's Minimum Data Set ([MDS] a federally mandated assessment tool) dated 8/28/2024, the MDS indicated Resident 26's was usually able to understand and be understood by others. The MDS indicated Resident 26 required oxygen therapy (a treatment that provides extra oxygen to residents with breathing problems). The MDS indicated Resident 26 was dependent on staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 26 required a mechanical altered diet (a meal plan that consists of foods that are soft and easy to swallow such as a pureed textured diet).</p> <p>During a review of Resident 26's Multidisciplinary Care Conference, (a meeting where the IDT discuss and plan care for the resident) dated 9/4/2024, the Care Conference indicated, Resident 26's needed monitoring related to medical management and observation related to complex medical conditions. The Care Conference indicated to keep the resident's head of bed (HOB) elevated due to the resident experiencing shortness of breath (SOB) when lying flat. The Care Conference indicated to always observe safety and aspiration precautions for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0657</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 10/31/2024 at 11:59 a.m. with the Director of Staff Development (DSD), the Multidisciplinary Care Conference, dated 9/4/2024 was reviewed. The DSD stated Resident 26's Care Plan should have been revised after the IDT identified the need to observe aspiration precautions for the resident, however, was not done.</p> <p>During a concurrent interview and record review on 10/31/2024 at 12:43 p.m. with the Director of Nursing (DON), the Multidisciplinary Care Conference, dated 9/4/2024 was reviewed. The DON stated, Resident 26 needed to always be monitored for safety and aspiration precautions. The DON stated the care plan should have been revised to add aspiration precaution interventions needed to prevent aspiration pneumonia for Resident 26.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated to ensure a comprehensive, person-centered, and interdisciplinary care that reflected best practice standards for meeting the health, safety, and environmental needs of residents, to obtain or maintain the highest physical, mental, and psychosocial well-being was developed for residents. The P&P indicated, the comprehensive care plan would be periodically reviewed and revised by Interdisciplinary Team (IDT). The P&P indicated the care plan would be reviewed and revised at the onset of new problems as appropriate and as necessary.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure one of one sampled resident (Resident 16) who had a stage 4 pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) was turned and reposition every two hours. <p>This deficient practice had the potential to worsen and delay wound healing.</p> <p>Findings:</p> <p>During review of Resident 16's Admission Record (front page of the chart that contains a summary of basic information about the resident), Resident 16's was admitted to the facility on [DATE] with diagnoses including anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), muscle weakness (loss of muscle strength), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/27/2024, the MDS indicated Resident 16's cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 40 was dependent (helper does ALL the efforts, resident does none of the effort to completes activity) or the assistance of two or more helpers was required for resident to complete the activity.</p> <p>During observation on 10/29/2024 at 10:07 a.m., Resident 16 was observed in her room lying in bed in supine (back) position.</p> <p>During observing on 10/29/2024 at 12:16 p.m., Resident 16 was observed in her room, lying in supine position.</p> <p>During observation 10/30/2024 at 8:16 a.m., Resident 16 was observed in her room, lying in supine position.</p> <p>During observation on 10/30/2024 at 10:19 a.m., Resident 16 was observed in her room, lying in supine position.</p> <p>During an interview with Certified Nurse Assistant (CNA) 4 on 10/31/2024 at 2:47 p.m., CNA 4 stated the resident can get worse if not turned and repositioned.</p> <p>During an interview with Licensed Vocational Nurse (LVN) 2 on 10/31/2024 at 2:53 p.m., LVN 2 stated there was nowhere specified on the electronic health record (EHR) to show Resident 16 was repositioned every two hours.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Osage Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 South Osage Ave Inglewood, CA 90301	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review on 10/31/2024 at 3:10 p.m., with Licensed Vocational Nurse (LVN) 4, to clarify Resident 16's care plan indicating frequent turning and repositioning, LVN 4 stated the intervention meant every two hours.</p> <p>During an interview on 10/31/2024 at 9:04 a.m. with the Director of Nursing (DON), the DON stated does not have signs posted turning residents with pressure ulcers at bed side. The DON clarified that frequent repositioning meant to reposition every two hours.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention dated 6/27/2024 indicated in section 3-b: Implement intervention identified in the plan of care which may include reposition and turning.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Ensure resident with long thick elongated (nail plate grows longer than the nail bed) toenails received podiatry (profession dealing with the specialized care of the feet) care services for one of one sampled resident (Resident 36).</p> <p>This deficient practice had the potential to result in discomfort and decline in physical mobility for Resident 36.</p> <p>Findings:</p> <p>During a review of Resident 36's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record, indicated Resident 36 was admitted to the facility on [DATE]. Resident 36's diagnoses included muscle weakness, iron deficiency anemia (a condition when your body does not have enough iron), and protein calorie malnutrition (a condition that occurs when someone doesn't consume enough protein, calories, and other nutrients).</p> <p>During a review of Resident 36's History and Physical (H&P), dated 10/6/2024, the H&P indicated, Resident 36 had the capacity to understand and make decisions.</p> <p>During a review of Resident 36's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 10/10/2024, the MDS indicated, Resident 36's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 36 required moderate assistance (helper does less than the effort) from staff with upper body dressing and personal hygiene.</p> <p>During a concurrent observation and interview on 10/29/2024 at 4:02 p.m., with Resident 36 in her room, Resident 36 had a long thick elongated toenails on both feet. Resident 36 stated she had been telling the facility staff about her long toenails and requested to see a podiatrist (a doctor who specializes in diagnosing and treating conditions that affect the foot, ankle, and lower leg) but nothing had been done. Resident 36 stated her long thick toenails prevented her from walking and it hurts when it touches the linen.</p> <p>During a concurrent observation and interview on 10/30/2024 at 9:37 a.m., at Resident 36's room, with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated Resident 36 had a long thick toenails since she was admitted to the facility. CNA 2 stated he was aware of Resident 36's long thick toenails and did not report to the Social Service Director (SSD) because it was not a serious condition.</p> <p>During an interview on 10/31/2024 at 9:46 a.m., with the SSD, the SSD stated she was in charge of referring all residents to podiatrist who needed foot care. The SSD stated resident with long thick elongated toenails should be referred to the podiatrist immediately because of the risk of ingrown toenail (a condition where the side or corner of a toenail grows into the skin beside it) that could cause pain and foot infection.</p> <p>(continued on next page)</p>		

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<p>F 0687</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, Foot Care, dated 1/1/2012, the P&P indicated, To provide hygienic care of the feet, to prevent skin breakdown or infection and to promote comfort.</p> <p>During a review of the facility's P&P titled, Grooming Care of the Fingernails and Toenails, dated 10/21/2021, the P&P indicated, High risk residents and residents with hypertrophic, myotic and keratotic toenails are referred to a podiatrist.</p> <p>During a review of the Job Description of the Social Service Coordinator, the Job Description indicated, To arrange ancillary services that have been determined necessary to maintain the residents concrete needs.</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** 46144</p> <p>Based on observation, interview, and record review the facility failed to:</p> <p>1. Ensure one of three sampled residents (Resident 26) bed was placed in the lowest position to prevent injuries during a fall.</p> <p>This deficient practice had the potential in the resident falling from the bed and sustaining an injury.</p> <p>Findings:</p> <p>During a review of Resident 26's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 26 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 26's diagnoses included chronic obstructive pulmonary (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (a chronic metabolic disease that causes high blood glucose levels), and gastro-esophageal reflux disease ([GERD] is a condition in which the stomach contents leak backward from the stomach into the esophagus).</p> <p>During a review of Resident 26's History and Physical (H&P), dated 7/7/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions.</p> <p>During a review of Resident 26's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/28/2024 the MDS indicated, Resident 26's cognition (ability to learn, reason, remember, understand, and make decisions) was resident usually understands. The MDS indicated Resident 26 was dependent on staff for toileting hygiene, showering, and dressing.</p> <p>During a review of Resident 26's care plan titled, The Resident is at risk for falls related to gait/balance problems, dated 9/4/2024, the care plan indicated Resident 26 will be free from falls. The staff intervention was to ensure Resident 26's bed was in the lowest position.</p> <p>During a concurrent observation and interview on 10/30/2024 at 11:45 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 26's room, CNA 3 stated the bed was too high and should be in the lowest position. CNA 3 stated the bed should be in the lowest position to prevent an injury if Resident 26 was to fall from the bed.</p> <p>During an interview on 10/31/2024 at 11:42 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 26 was at high risk for falls. The DSD stated Resident 26's bed should have been in the lowest position. The DSD stated when the bed was in a high position, if Resident 26 fell off the bed, it could result in an injury.</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 the facility's policy and procedure (P&P), Fall Management Program, dated 3/2021, the P&P indicated, to provide residents a safe environment that minimizes complications associated with falls. The P&P indicated the facility will implement a fall management program that supports providing an environment free from fall hazards.</p> <p>During a review of the facility's policy and procedure (P&P), Resident Safety, dated 4/2021, the P&P indicated, to provide a safe and hazard free environment. The P&P indicated after a risk evaluation is completed, a resident centered care plan will be developed to mitigate safety risk factors. The P&P indicated the staff will observe the safety and well-being of the residents and to check around the clock by nursing service personnel.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</p> <p>Based on interview and record review, the facility failed to:</p> <p>1. Ensure one of one sampled resident (Resident 146) was provided with a scheduled toileting plan, per bowel and bladder assessment.</p> <p>This deficient practice had the potential for decline in bladder and bowel function for Resident 146.</p> <p>Finding:</p> <p>During a review of Resident 146's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 146 was admitted to the facility on [DATE]. Resident 136's diagnoses included muscle weakness, nondisplaced fracture of greater trochanter of left femur (a break in the top of the thigh bone near the hip), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty of breathing.</p> <p>During a review of Resident 146's History and Physical (H&P), dated 10/23/2024, the H&P indicated, Resident 146 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 146's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 10/28/2024, the MDS indicated, Resident 146's cognitive (ability to think and reason) for daily decision making was severely impaired. The MDS indicated, Resident 146 was totally dependent (helper does all of the effort) from staff with toileting hygiene and lower body dressing. The MDS also indicated, a trial of toileting program such as scheduled toileting (a technique that involves using a set schedule to go to the bathroom) or bladder training (type of training that will help a person manage urinary incontinence) have not been attempted.</p> <p>During a concurrent interview and record review on 10/30/2024 at 4:13 p.m., with the MDS Nurse, Resident 146's Bowel and Bladder Program Screener was reviewed. The Bowel and Bladder Program Screener indicated; Resident 146 had a total score of 7 (candidate for schedule toileting). The Bowel and Bladder Program Screener indicated, Resident 146's mental status was forgetful but follows commands. The MDS Nurse stated, Resident 146 would benefit from Scheduled toileting program to reduce problem with incontinence (inability to control the flow or urine or stool). The MDS Nurse stated scheduled toileting plan was essential for all residents to monitor their bowel and bladder pattern. The MDS Nurse stated there was no documented evidence in the clinical records of Resident 146's indicating staff implemented a scheduled toileting plan.</p> <p>During an interview on 10/30/2024 at 4:37 p.m., with the Director of Nursing (DON), the DON stated a scheduled toileting plan is a set schedule every 2 to 3 hours for resident to be assisted to the bathroom or to offer bedside commode (a portable toilet that can be used by people who are unable to walk to the bathroom but can get out of bed). The DON stated the goal of scheduled toileting plan was to help residents with incontinence managed their bowel and bladder safely, keep them clean and dry to prevent the risk of skin breakdown and decrease in motor function and mobility.</p> <p>(continued on next page)</p>		

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<p>F 0690</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, Bowel and Bladder Training/Toileting Program, dated 8/21/2020, the P&P indicated, Each resident who is incontinent of bowel and/or bladder is identified, assessed and provided appropriate treatment and services to achieve or maintain as much as normal bladder/bowel functions as possible. The P&P also indicated following review and determination of the resident's voiding/bowel evacuation program; the licensed nurse will develop an individualized scheduled toileting program to meet the resident needs.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</p> <p>Based on interview and record review, the facility failed to:</p> <p>1. Ensure one of one sampled residents received hemodialysis ([HD] a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed) treatment received care in accordance with standards of practice for one of two sampled residents (Resident 9) by failing to communicate to Resident 9's physician regarding Registered Dietitian ([RD] a health professional in nutrition) recommendation to provide Nova source (a high calorie, nutritional supplement designed for those on dialysis) supplement.</p> <p>This deficient practice had the potential to result in weight loss and malnutrition that can lead to worsened health complication for Resident 9.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), muscle weakness congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>During a review of Resident 9's History and Physical (H&P), dated 12/11/2023, the H&P indicated, Resident 9 had the capacity to understand and make decisions.</p> <p>During a review of Resident 9's Minimum Data Set ([MDS] - a federally mandated resident assessment tool) annual assessment, dated 9/25/2024, the MDS indicated, Resident 9's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 9 required maximum assistance (helper does more than half the effort) from staff with toileting hygiene and upper and body dressing.</p> <p>During a review of Resident 9's Order Summary Report (a document containing active orders), dated 10/1/2024, the Order Summary Report indicated, Resident 9 had a physician's order of dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) every Tuesday, Thursday, and Saturday.</p> <p>During a review of Resident 9's care plan titled Resident has potential nutritional problem related to disease process dated 10/2/2023, indicated goal of Resident 9 to maintain adequate nutritional status with no signs and symptoms of malnutrition daily through next review date of 12/23/2024. The care plan indicated intervention for RD to evaluate and make diet change recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 10/31/2024 at 12:25 p.m., with the RD, Resident 9's Nutritional Risk Assessment, dated 9/20/2024 was reviewed. The RD stated she did recommend to provide Novasource supplement 1 can (237 milliliter ([ml] unit of volume) daily as nutritional intervention since Resident 9 had a variable oral intake. The RD stated there was no documentation indicating the physician was notified regarding RD's recommendation to give Resident 9 Novasource 1 can daily.</p> <p>During an interview on 10/31/2024 at 3:09 p.m., with the Director of Nursing (DON), the DON stated all RD recommendations should be reported to the physician by the licensed nurses within 72 hours. The DON stated the licensed nurses did not communicate to the physician of Resident 9's RD recommendation because the facility did not have available supply of Novasource supplement. The DON stated by not providing Novasource supplement, Resident 9 would be at risk for weight loss and dehydration that could contribute to Resident 9's decline in health condition.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, dated 10/1/2018, the P&P indicated, The Nursing staff, Dialysis Provider Staff, and the Attending physician will collaborate on a regular basis concerning the resident's care.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Label with an open date of ketorolac (a medication used to treat swelling and redness after eye surgery) and prednisolone acetate (a medication used to treat infection before and after eye surgery)) ophthalmic solution (liquid eye drops) for Resident 34.</p> <p>This deficient practice had the potential for harm to Resident 34 due to the potential loss of strength of medication.</p> <p>2. Label with an open date and remove one pouch of expired ipratropium with albuterol (a combination solution use to treat and prevent shortness of breath) inhalation solution for Resident 40.</p> <p>This deficient practice had the potential to result in prolonged use and loss of strength of the expired inhalation solution and can lead to ineffective treatment of respiratory symptoms for Resident 40.</p> <p>Findings:</p> <p>1. During a review of Resident 34's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 34's diagnoses included glaucoma (a chronic eye disease that can cause vision loss and blindness), muscle weakness and hypertension ([HTN]-high blood pressure).</p> <p>During a review of Resident 34's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 34 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 34's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated ,d+[DATE]/2024, the MDS indicated, Resident 34's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 34 required setup assistance (helper assists only prior to or following the activity) from staff with eating and oral hygiene.</p> <p>During a review of Resident 34's Order Summary Report (a document containing active orders), dated [DATE], the Order Summary Report indicated, Resident 34 had a physician's order of ketorolac ophthalmic solution 1 drop (unit of measure of volume) in left eye four times a day and prednisolone acetate 1 drop in left eye every 6 hours to reduce inflammation (a normal part of the body's response to injury or infection) after eye surgery.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on [DATE] at 10:33 a.m., of the medication cart 3 with Licensed Vocational Nurse (LVN 1), found one opened ketorolac ophthalmic solution with no open date and one opened prednisolone acetate suspension solution with no open date for Resident 34. LVN 1 stated the ketorolac ophthalmic solution and prednisolone acetate suspension indicates a pharmacy fill date of [DATE]. LVN 1 stated it was the responsibility of the licensed nurse who opened the medication to put a date opened and label it. LVN 1 stated labeling medication with an open date was important to know the validity and when to discard the medication.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Labels, dated ,d+[DATE], the P&P indicated, Medications are labeled in accordance with facility requirements and state and federal laws.</p> <p>2. During a review of Resident 40's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 40 was admitted to the facility on [DATE]. Resident 40's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing) 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 40's History and Physical (H&P), dated [DATE], 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 Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated [DATE], the MDS indicated, Resident 40's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 40 required setup assistance (helper assists only prior to or following the activity) from staff with eating, oral hygiene, and personal hygiene.</p> <p>During a review of Resident 40's Order Summary Report (a document containing active orders), dated [DATE], the Order Summary Report indicated, Resident 40 had a physician's order of ipratropium with albuterol 3 milliliter ([ml] unit of volume) to be administered by inhaling orally via nebulizer (a device used to inhale the medication) every 6 hours as needed for shortness of breath.</p> <p>During a concurrent observation and interview on [DATE] at 10:56 a.m., of the medication cart 2 with Licensed Vocational Nurse (LVN 1), found one opened and expired ipratropium with albuterol inhalation foil pack for Resident 40 stored at room temperature and not labeled with a date on which the foil pack was opened. LVN 1 stated the ipratropium with albuterol solution for Resident 40 indicates a pharmacy fill date of [DATE]. LVN 1 stated it was unknown at this time when the ipratropium with albuterol solution foil pack for Resident 40 was opened. LVN 1 stated giving expired ipratropium with albuterol solution for Resident 40 can be ineffective in treating her symptoms of shortness of breath that would likely require hospitalization .</p> <p>During an interview on [DATE] at 10:40 a.m., with the Director of Nursing (DON), the DON stated all medications should be labeled with an open date and expiration date to evaluate the efficacy of the medications. The DON stated giving expired medication would have a potential adverse reaction to resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Osage Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 South Osage Ave Inglewood, CA 90301	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the manufacturer's product storage and labeling, opened foil packs of ipratropium with albuterol solutions should be stored at room temperature between 36 and 77 degrees Fahrenheit and once removed from foil pouch, the individual vials should be used within one week.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Ensure a sandwich for one of five sampled resident (Resident 40) was identified with a label and date.</p> <p>This deficient practice placed Resident 40 at risk for foodborne illness (any illness resulting from eating contaminated/spoiled foods).</p> <p>Findings:</p> <p>During review of Resident 40's Admission Record (front page of the chart that contains a summary of basic information about the resident), Resident 40 was admitted to the facility on [DATE] with diagnoses including anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and muscle weakness (loss of muscle strength)</p> <p>During a review of Resident 40's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/18/2024, the MDS indicated Resident 40's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 40 required setup or clean up assistance (helper set up or clean up; resident completes activity) from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a concurrent observation and interview on 10/30/2024, at 11:02 a.m. with Resident 40, in Resident 40's room, observed an undated and unlabeled sandwich on top of the bed side table. Resident 40 stated, I don't know, but this sandwich looks old and ready to throw in the trash.</p> <p>During an interview with the Dietary Service Supervisor (DSS), the DSS stated she had no answer to when food needed to be disposed but hoped the staff discarded the old ones because residents will have a potential for food poisoning. The DSS stated, the best way and best practice was to label and date each food item.</p> <p>During an interview with Registered Dietitian (RD) on 10/31/24 at 12:14 p.m., the RD stated, all sandwiches need to be identified with a label and date. The RD stated if residents ate food that was old, the residents can get food poisoning or get sick.</p> <p>During a review of the facility's policy and procedure Title, (food storage) dated 7/25/2019, indicated all food items will be stored, thawed, and prepared in accordance with good sanitary practice. all items will be correctly label and dated.</p>		

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NAME OF PROVIDER OR SUPPLIER Osage Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 South Osage Ave Inglewood, CA 90301	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144</p> <p>Based on observation, interview, and record review the facility failed to:</p> <p>1. Ensure one out of three sampled residents (Resident 26) nasal cannula (a medical device that provides supplemental oxygen to a patient through their nose) was dated and labeled.</p> <p>This deficient practice placed Resident 26 at risk for a respiratory infection (an infectious disease that affects the respiratory system, which is responsible for breathing).</p> <p>Findings:</p> <p>During an observation on 10/29/2024 at 10:15 a.m. and 10/30/2024 at 10:52 a.m. in Residents 26's room, Resident 26's nasal cannula was not dated and labeled.</p> <p>During a review of Resident 26's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 26's diagnoses included chronic obstructive pulmonary (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (a chronic metabolic disease that causes high blood glucose levels), and gastro-esophageal reflux disease ([GERD] is a condition in which the stomach contents leak backward from the stomach into the esophagus).</p> <p>During a review of Resident 26's History and Physical (H&P), dated 7/7/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions.</p> <p>During a review of Resident 26's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/28/2024 the MDS indicated, Resident 26's cognition (ability to learn, reason, remember, understand, and make decisions) was resident usually understands. The MDS indicated Resident 26 required oxygen therapy (a treatment that provides extra oxygen to people with breathing problems). The MDS indicated Resident 26 was dependent on staff for toileting hygiene, showering, and dressing.</p> <p>During a concurrent observation and interview on 10/31/2024 at 12:18 p.m. with the Director of Staff Development (DSD), in Resident 26's room, Resident 26's nasal cannula did not have a date and was not labeled. The DSD stated the nasal cannula should be changed every week. The DSD stated the staff should put the date on the nasal cannula. The DSD stated if the nasal cannula is not changed the nostrils (one of the two external openings of the nose that allow air to flow into the nasal cavity and lungs) area can get dirty and after a week could clogged. The DSD stated Resident 26 could become sick if the nasal cannula is not change weekly and dated.</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 - Few</p>	<p>During a concurrent observation and interview on 10/31/2024 at 1:08 p.m. with Director of Nursing (DON), in Resident 26's room, Resident 26's nasal cannula did not have a date and was not labeled. The DON stated the nasal cannula should have a date on the nasal cannula and changed weekly. The DON stated the nasal cannula should be dated so the staff will know when it needs to be changed. The DON stated the date indicated on the nasal cannula would let the staff know when it was applied to the resident. The DON stated not having the date on the nasal cannula placed the resident at risk for respiratory infection.</p> <p>During a review of facility's policy and procedure (P&P) titled, Oxygen Therapy, dated 11/2017, the P&P indicated, oxygen is administered under safe and sanitary conditions to meet resident needs. The P&P indicated the tubing should be changed no more than every 7 days and labeled with the date of changed.</p>

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<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49906</p> <p>Based on observation, interview and record review, the facility failed to:</p> <p>1. Ensure two of 19 sampled resident rooms (rooms [ROOM NUMBERS]) accommodated no more than four residents per room.</p> <p>This deficient practice had the potential to result in and/or create safety hazards, lack of privacy, and care issues for the residents.</p> <p>Findings:</p> <p>During observations of rooms [ROOM NUMBERS] from 10/29/2024 through 11/1/2024, room [ROOM NUMBER] beds (B and c) and room [ROOM NUMBER] bed (D) were empty. There were no noted concerns with the privacy and care issues for the residents.</p> <p>During a review of the letter Client Accommodations Analysis completed by the facility on 10/29/2024, the form indicated room [ROOM NUMBER] beds (A, B, C, D, and E) and room [ROOM NUMBER] beds (A, B, C, D, and E) accommodated five residents.</p> <p>During a review of the Request for Waiver/Variance to Section 483.70 dated 10/29/2024, the Administrator requested a renewal for a variation of the above variance.</p>